TEAMSTERS UNION LOCAL No. 377 HEALTH AND WELFARE FUND

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Updated September 1, 2012

Teamsters Union Local No. 377
Health and Welfare Fund
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TEAMSTERS UNION LOCAL No. 377 HEALTH AND WELFARE FUND

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INTRODUCTION

The Board of Trustees is pleased to provide this updated Plan document and Summary Plan Description of the benefits available through Teamsters Union Local No. 377 Health and Welfare Fund. This booklet replaces any and all booklets that were previously issued. Please read this booklet and keep it in a safe place for future reference. It explains when you and your dependents are eligible for benefits, what your benefits are and how claims are processed for your benefits. This program was adopted by the Board of Trustees and involves some important cost management measures for you and your dependents.

This booklet describes the health and welfare benefits available to you and has been issued according to the terms of the Group Contract. The actual Group Contract is between Medical Mutual of Ohio and the Fund.

Medical Mutual Services through an affiliated company has agreements with Providers, including hospitals. Some of these agreements allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of Medical Mutual Services and Medical Mutual Services will retain any payments resulting therefrom; however, the deductibles, copayments, coinsurance and benefit maximum accumulations shall be calculated as described in this booklet.

ADVANTAGES

Your health benefit plan gives you the option to choose your own personal physician, specialist and hospital facility from the provider network directory. For maximum benefits, utilize the SuperMed Plus™ providers at identified locations only.

Throughout this booklet you will be informed of network and non-network health care benefits available to you and your family. Medical Mutual works with contracting hospitals, physicians and other providers in order to make quality medical care readily accessible and affordable.

You will receive the maximum benefits for physician and hospital care, when you choose a contracting physician or hospital. By selecting a personal physician, you can establish a comfortable, personal relationship with a physician who is familiar with your medical history and personal needs. Your personal physician is better able to direct you to specialists or other providers and help you control your health care costs.

This does not mean you cannot see your current physician or specialist if he or she is not listed in the directory. You do have the freedom to seek care outside the network and still receive part of your benefits.

Services obtained from a physician or other professional provider who is not part of the network, will be paid based on the Allowed Amount as established by Medical Mutual. You will be responsible for any difference between the Allowed Amount and the Provider's normal charge if you go to a non-participating, non-network provider. If you go to a non-network provider, you will be responsible for the non-network coinsurance and deductible.

HOSPITAL CARE

All contracting hospitals have agreed to provide specific services at a negotiated rate, so you will receive the maximum benefit amount by having your physician select a network contracting hospital.

All non-emergency, scheduled hospitalizations must be reviewed and certified by the PReview managed care department at Medical Mutual before you go into a hospital or other treatment facility. This procedure is called pre-admission review. When you use a contracting hospital, the hospital will take care of the pre-admission review and notification process for you.

In emergency situations, always go to the nearest hospital for treatment.

When using a non-contracting or out-of-state hospital, you have the responsibility to contact Medical Mutual prior to admission; unless it is an emergency situation, at which point you should seek care at the nearest facility.

Keep in mind that this booklet describes benefits available to active employees as well as eligible retirees. However, certain benefits are only available to active employees (not retirees), including but not limited to accidental death and dismemberment, weekly disability, and dental and vision benefits.

Please read the following summary carefully. It has been written in simple, non-technical language, and is intended to help you understand how this Plan will benefit you and your eligible dependents.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

PAGE

SECTION 1 – SUMMARY OF BENEFITS **1**

SUMMARY OF BENEFITS 1
BENEFITS PROVIDED BY THE FUND OFFICE 4
EMPLOYEE ASSISTANCE PROGRAM (EAP) 5
PRESCRIPTION DRUG BENEFIT 6

SECTION 2 – ELIGIBILITY (FOR EMPLOYEES AND THEIR FAMILIES) **7**

COVERAGE BEGINS 8
TERMINATION/REINSTATEMENT OF COVERAGE 9
CONTINUING ELIGIBILITY 10
SELF-CONTRIBUTION 10
TERMINATION 11
CERTIFICATE OF CREDITABLE COVERAGE AFTER YOU LOSE COVERAGE UNDER THIS PLAN 11
CHANGES IN COVERAGE 11
DEPENDENT ELIGIBILITY 12
COVERAGE FOR INDIVIDUALS WHO RECEIVE A SOCIAL SECURITY DISABILITY AWARD 12

SECTION 3 – ELIGIBILITY (FOR RETIREES AND THEIR FAMILIES) **13**

COVERAGE FOR INDIVIDUALS WHO RECEIVE A SOCIAL SECURITY DISABILITY AWARD 14
DEPENDENT ELIGIBILITY 14
TERMINATION 14
CERTIFICATE OF CREDITABLE COVERAGE AFTER YOU LOSE COVERAGE UNDER THIS PLAN 15
CHANGES IN COVERAGE 15
SPECIAL MATTERS 15

SECTION 4 – DEATH BENEFIT (FOR EMPLOYEES ONLY) **16**

CLAIM PAYMENTS 16
CLAIM FILING FOR BENEFITS 16
EXCLUSIONS TO DEATH BENEFIT 17

TABLE OF CONTENTS

PAGE

SECTION 5 – DEATH BENEFIT (FOR RETIREES ONLY)....................................18

CLAIM PAYMENTS....................................18
CLAIM FILING FOR BENEFITS....................................18
EXCLUSIONS TO DEATH BENEFIT....................................19

SECTION 6 – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (FOR EMPLOYEES ONLY)....................................20

CLAIM PAYMENTS....................................20
CLAIM FILING FOR BENEFITS....................................21
EXCLUSIONS TO ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS ..21

SECTION 7 – WEEKLY DISABILITY BENEFIT (FOR EMPLOYEES ONLY)........22

EXCLUSIONS FOR WEEKLY DISABILTY BENEFITS....................................22

SECTION 8 – HOSPITAL SERVICES....................................23

UTILIZATION REVIEW....................................23
HOSPITAL EXPENSE BENEFIT....................................23
SURGICAL EXPENSE BENEFIT FOR HOSPITAL SERVICES ONLY....................................24
EMERGENCY ACCIDENT/ILLNESS BENEFIT....................................25
NON-EMERGENCY ACCIDENT/ILLNESS BENEFIT....................................25
OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY EXPENSE BENEFIT ..25
SKILLED NURSING FACILITY BENEFIT....................................26
HOME HEALTH CARE BENEFIT....................................27
HOSPICE CARE BENEFIT....................................27
AMBULANCE SERVICE HOSPITAL BENEFIT....................................28
ORGAN TRANSPLANT SERVICES....................................28
DURABLE MEDICAL EQUIPMENT (HOSPITAL CHARGES ONLY)....................................29
INPATIENT PSYCHIATRIC BENEFIT....................................30
INPATIENT SUBSTANCE ABUSE BENEFIT....................................30

TABLE OF CONTENTS

PAGE

SECTION 9 – PROFESSIONAL SERVICES 32

INPATIENT MEDICAL BENEFITS 32
INPATIENT CONSULTATIONS 32
SURGERY BENEFIT (INPATIENT OR OUTPATIENT
PROFESSIONAL SERVICES) 32
ANESTHESIA BENEFIT 33
ASSISTANT AT SURGERY 33
EMERGENCY ACCIDENT/ILLNESS BENEFIT 33
AMBULANCE SERVICE BENEFIT 33
NON-EMERGENCY ACCIDENT/ILLNESS BENEFIT 34
MATERNITY AND ABORTION BENEFIT 34
INITIAL NEWBORN EXAM 34
HOME AND OFFICE CALLS 34
ADULT ROUTINE PHYSICAL EXAMS 34
ALLERGY TESTS AND TREATMENTS 34
IMMUNIZATIONS 34
ROUTINE PAP SMEAR, CHEST X-RAY, SMA12, CBC, URINALYSIS,
MAMMOGRAM AND EKG 34
WELL CHILD VISITS AND IMMUNIZATIONS 35
DIAGNOSTIC SERVICES, RADIOLOGY, PATHOLOGY, AND ALLERGY
TESTING 35
THERAPY SERVICES (INPATIENT AND OUTPATIENT) 35
SKILLED NURSING FACILITY (MEDICAL VISITS) 35
DURABLE MEDICAL EQUIPMENT 36
OUTPATIENT PSYCHIATRIC AND SUBSTANCE ABUSE BENEFIT 37
DENTAL SERVICES FOR AN ACCIDENTAL INJURY 37
SMOKING CESSATION SERVICES 38
URGENT CARE SERVICES 38

**SECTION 10 – COMBINED DENTAL AND VISION BENEFIT
(FOR EMPLOYEES AND THEIR FAMILIES ONLY) 39**

ORTHODONTIC SERVICES 39
CLAIM PROCEDURES 39

SECTION 11 – PRESCRIPTION DRUG BENEFIT 40

THE BENEFIT AND HOW TO USE IT 40
EXCLUSIONS 40
PRESCRIPTION DRUG COVERAGE AND MEDICARE 40

TABLE OF CONTENTS

PAGE

SECTION 12 – EMPLOYEE ASSISTANCE PROGRAM......................................41

SECTION 13 – GENERAL EXCLUSIONS..42

SECTION 14 – COORDINATION OF BENEFITS..46

COORDINATION WITH MEDICARE 47
FOR PARTICIPANTS OR DEPENDENTS WHO ARE ELIGIBLE
FOR MEDICARE...48

SECTION 15 – SUBROGATION AND REIMBURSEMENT 49

WORKERS COMPENSATION...51

SECTION 16 – CLAIMS APPEALS PROCEDURES...52

CLAIM FILING AND PAYMENT...52
HOW TO FILE A CLAIM UNDER THE MEDICAL MUTUAL MEDICAL PLAN........53
HOW TO FILE A CLAIM FOR DENTAL AND VISION BENEFITS..........................56
HOW TO FILE A CLAIM FOR PRESCRIPTION BENEFITS UNDER
THE E.S.I. PROGRAM..57
HOW TO FILE A CLAIM FOR DEATH, ACCIDENTAL DEATH AND
DISMEMBERMENT BENEFITS...59
HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS 59
PROOFS OF CLAIM 60
PHYSICAL EXAMINATION AND AUTOPSY 60
LEGAL ACTION 60
APPEAL PROCESS..61
REVIEW PROCEDURE FOR MEDICAL CLAIMS PROVIDED THROUGH
MEDICAL MUTUAL...61
REVIEW PROCEDURE FOR DENTAL, VISION, PRESCRIPTION,
DEATH, DISMEMBERMENT AND WEEKLY DISABILITY BENEFITS 65
VOLUNTARY APPEAL TO THE BOARD OF TRUSTEES.......................................66
DECISION ON APPEAL TO BE FINAL...67

SECTION 17 – MILITARY SERVICE PROVISION..68

SECTION 18 – CONTINUATION OF COVERAGE-COBRA 69

SECTION 19 – HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT 71

TABLE OF CONTENTS

PAGE

SECTION 20 – FAMILY AND MEDICAL LEAVE ACT OF 1993 .... **72**

REPAYMENT OF CONTRIBUTIONS TO EMPLOYER 73

SECTION 21 – WOMENS HEALTH AND CANCER RIGHTS ACT OF 1998 .... **74**

SECTION 22 – NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT **75**

SECTION 23 – MENTAL HEALTH PARITY AND ADDICTION ACT OF 2008 .... **76**

SECTION 24 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) **77**

SECTION 25 – GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 .... **87**

SECTION 26 – IMPORTANT INFORMATION ABOUT THE PLAN **88**

SECTION 27 – STATEMENT OF ERISA RIGHTS **90**

SECTION 28 – HIPAA SECURITY **92**

SECTION 29 – DEFINITIONS **93**

SECTION 1

SUMMARY OF BENEFITS

Death, AD&D and Lost Time Benefits (Applies to Employee only)	Maximum Payable	
Death Benefit	$25,000	
Accidental Death & Dismemberment	$25,000	
Accident and Sickness Time Loss Benefit	$200 per week (26 week maximum)	
Death Benefit (Applies to Retiree Only)	$2,000 (maximum payable)	
Medical Benefits (Applies to Employees, Retirees and Covered Dependents)	**Network**	**Non-Network**
Benefit Period	January 1st through December 31st	
Dependent Age	**26** Removal upon End of Month	
Benefit Period Deductible – Single/Family[1]	$500 / $1,000	$1,000 / $2,000
Coinsurance	80%	60%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$5,000 / $10,000	
Lifetime Maximum	Unlimited	
4 Month Deductible Carryover	Applies only for period of September 1, 2012 – December 31, 2012	
Physician/Office Services		
Office Visit to PCP (Illness/Injury)[2]	$20 copay, then 100%	60% after deductible
Specialist Office Visit (Illness/Injury)[2]	$40 copay, then 100%	60% after deductible
Urgent Care Office Visit [2]	$20 copay, then 100%	60% after deductible
Diagnostic Services - rendered in the Physician's Office	100%	60% after deductible
Immunizations (All Tetanus Toxoid Vaccines – Illness/Injury)	80% after deductible	60% after deductible
Immunizations	100%	60% after deductible
Preventive Services		
Preventive Service in accordance with federal law[3]	100%	60% after deductible
Routine Adult Physical Exams (Ages 21 and over; One per calendar year)	100%	60% after deductible
Well Child Care Services including Exams (7 exams in 1st 12 months), Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Lab Tests (up to age 21)	100%	60% after deductible
Routine Mammogram	100%	60% after deductible

Routine Gynecological Exam (One exam per calendar year)	100%	60% after deductible
Routine EKG, Chest X-ray, Complete Blood Count (CBC), Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100%	60% after deductible
Cholesterol Screening, Prostate Specific Antigen (PSA), Colon Cancer Screening (All Ages)	100%	60% after deductible
Influenza Virus Vaccine (All ages)	100%	60% after deductible
Endoscopic Services[4]	100%	60% after deductible
Preventative Immunizations (Age 21 and over)	100%	60% after deductible
Routine Audiometric (Hearing) Examination (one (1) per Benefit Period)	100%	60% after deductible
Outpatient Services		
Surgical Services	80% after deductible	60% after deductible
Diagnostic Services – rendered other than a physician's office	80% after deductible	60% after deductible
Physical Therapy, Occupational Therapy and Chiropractic - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	60% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
Emergency use of an Emergency Room[5]	$100 copay, then 80% after deductible	
Non-Emergency use of an Emergency Room	Not covered	Not covered
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	60% after deductible
Maternity (limited to EE and SP only)	80% after deductible	60% after deductible
Skilled Nursing Facility (730 day w/90 day renewal; prof svcs unlimited)	80% after deductible	60% after deductible
Organ Transplants (includes professional services)	80% after deductible	60% after deductible
Additional Services		
Allergy Testing	80% after deductible	60% after deductible
Allergy Treatments	80% after deductible	60% after deductible
Case Management	100%	100%
Emergency use of Ambulance	80% after deductible	60% after deductible
Non-emergency use of Ambulance	Not covered	Not covered
Oral Accident	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Jobst/Compression Stockings	80% after deductible	60% after deductible
Home Healthcare	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse	80% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse	80% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse Office Visit	$20 copay, then 100%	60% after deductible

Hearing Aid Benefit	
Conformity Evaluation (1 every rolling 36-months)	100% up to $150.00 maximum ($150 maximum combined with Hearing Aid Evaluation Test)
Hearing Aid (1 per ear every rolling 36-months)	80% after deductible (up to $1500 maximum per appliance per year)
Hearing Aid Evaluation Test (1 every rolling 36-months)	100% up to $150.00 maximum ($150 maximum combined with Conformity Evaluation)

Important footnotes:

Network services will apply to only the Network deductible. Non Network services will apply to only the Non-Network deductible.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

In certain instances, Medical Mutual's payment may not equal the percentage listed above. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual's negotiated rate with the provider.

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[1] Maximum family deductible. Member deductible is the same as single deductible.

[2] The office visit copay applies to the cost of the office visit only. The following Primary Care Providers are subject to the $20.00 Co Pay: General Practice, Family Practice, Internal Medicine, Obstetrics and Gynecology (OB/GYN), Pediatrics/Neonatology, Certified Nurse Practitioner/ Physician Assistant, Geriatric, All Travel/Other Network Providers, Psychiatry, Geriatric Psychiatry, Child and Adolescent Psychiatry, Addiction Psychiatry, Psychology, Licensed Independent Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage-Family Therapist. *All other providers will be considered specialists and are subject to the $40.00 Co Pay.*

[3] Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
With respect to well-woman visits, the frequency of visits is annual although in accordance with Affordable Care Act the Plan recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors and will be covered accordingly.

[4] Incidental services related to endoscopic services are subject to the Plan's network and non-network benefits. Examples of incidental services include pathology.

[5] Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

BENEFITS PROVIDED BY THE FUND OFFICE

COMBINED DENTAL AND VISION SERVICE BENEFIT (FOR EMPLOYEES AND THEIR FAMILIES ONLY)

Maximum for single policy	**80% of $1,250.00 per year**
Maximum for family policy	**80% of $1,250.00 per year**

(Dependents under age 19 are not subject to the annual limits listed above)

The Fund will consider all dental and vision services with no restrictions on frequency for covered procedures provided by a licensed Dentist, Physician or Vision Supplier up to the maximum allowance stated above.

Special prescription lenses or contact lenses, which are required to correct cataract surgery and extensive eye examinations by an ophthalmologist because of a disease of the eye, are covered separately under the medical benefit.

Eligibility rules for dental and vision benefits are the same as those for other benefits under the Plan. Benefits will be paid only for services which are performed while the covered person is eligible.

ORTHODONTIC BENEFIT

Lifetime maximum	**$1,000 per individual**

Orthodontic services will be covered for all eligible participants and their dependents up to the Lifetime maximum.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Fund offers an Employee Assistance Program for family, financial, legal, and emotional or other personal problems for all eligible members and their eligible dependents who DO NOT have an employee assistance program available to them through their employer. Effective January 1, 2014, this program will be offered through ComPsych. For additional information, please contact the Fund Office.

PRESCRIPTION DRUG BENEFIT

P.O. Box 66583, St. Louis, MO 63166

www.express-scripts.com

1.800.467.2006

<u>Generic Preferred Program:</u> If you choose the generic, your copayment will be the cost of your prescription up to $15.00. If you choose the brand-name, you will pay a copayment of $15.00 ***plus*** the difference in cost between the generic and the brand-name drug even if your physician indicates dispense as written.

<u>Step Therapy Program:</u> Step Therapy encourages the use of generic medications.

- Step 1 – Try the front-line generic or lower-cost brand medication, proven to be safe, effective and affordable.
- Step 2 – If the front-line generic does not work for you, you will automatically be able to fill the more expensive brand-name back-up medication.

	RETAIL PHARMACY	MAIL ORDER
Generic Drugs	$ 15.00 Co-Pay	$ 30.00 Co-Pay
Brand Formulary	$ 30.00 Co-Pay	$ 60.00 Co-Pay
Brand Non-Formulary	$ 60.00 Co-Pay	$120.00 Co-Pay
Generic Oral Contraception	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Brand Formulary and Non-Formulary Oral contraception will continue to be subject to medical necessity, Co-Pay applies	
Generic OTC Aspirin	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Men ages 45 to 79 years and women ages 55 to 79. To prevent cardiovascular disease. Physician prescription required.	
Generic Fluoride Rx Products	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Preschool children older than 6 months of age through 5 years old. Physician prescription required.	
Generic Folic Acid OTC/Rx Products	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Women of child bearing age (18 to 45). Physician prescription required.	
Generic Iron Supplements OTC/Rx Products	$ 0.00 Co-Pay	$ 0.00 Co-Pay
	Children ages 6 to 12 months who are at increased risk for iron deficiency anemia. Physician prescription required.	

EXCLUSIONS

Fertility drugs, Smoking cessation drugs, Genetically Engineered drugs, Immune Altering drugs, and Non-Generic Federal Legend Oral Contraceptives will be excluded. (Some exceptions apply. Please contact the Fund Office for further information).

PHARMACY EXCLUSIONS

☆Wal-Mart ☆Walgreens ☆Marc's

The ESI card is not valid at these pharmacy chains nor will there be any reimbursement eligibility for non-emergency prescriptions.

In the event that a network pharmacy is not available for medical emergencies a claim may be submitted directly to the Fund office for consideration of reimbursement minus the applicable co-payment.

SECTION 2
ELIGIBILITY
(FOR EMPLOYEES AND THEIR FAMILIES)

This section tells how to apply for coverage, how and when you become eligible for coverage, who is considered a Dependent, and when your coverage starts. This section also explains when you should change from individual to family coverage and how you should apply for the change.

To enroll you must complete an application card, but no physical examination is required. You can enroll for either individual or family coverage. You will receive an identification card from Medical Mutual of Ohio, which shows your identification number. If you have family coverage, it is important for you to know which family members are eligible for benefits.

You can become eligible for the benefits provided under the Fund if:

- You are a member of the bargaining unit represented for purposes of collective bargaining by Teamsters Local Union No. 377, and
- Your employer has entered into a collective bargaining agreement with Teamsters Local Union No. 377 providing for contributions to be made to the Fund, and is required to and actually makes the necessary contributions on your behalf to the Fund, and
- Your employer has signed a written agreement with the Board of Trustees authorizing the necessary contributions to be made on your behalf.
- If you, your spouse or other Dependent had medical coverage under Medicaid or a state child health insurance plan (a "CHIP" plan) but lose eligibility for that Medicaid or CHIP coverage and request coverage under the Plan within 60 days after such coverage terminates; or
- If you, your spouse or other Dependent becomes eligible for state CHIP assistance or coverage under Medicaid and request coverage under the Plan within 60 days after you or your Dependent are determined to be eligible for such assistance.

You are not eligible if you are an employer, partner, self-employed person, proprietor, or a dependent of such an individual.

COVERAGE BEGINS

Coverage starts on your effective date, which is determined as follows:

If you begin work for a contributing employer who has participated in the Fund for at least three (3) months, your effective date will be contingent upon the receipt of two (2) full consecutive monthly contributions from a contributing employer on your behalf. (Most employers pay contributions based on weeks worked. Therefore, a full contribution includes all weeks for that month). Your effective date is the beginning of the fourth (4th) month after satisfying these requirements.

The following schedule reflects a participant's effective date based on the first month of contributions made.

> **Example:** Employer's initial contributions for Participant are the full consecutive months of December and January. Participants' effective date is March 1st (i.e., the first of the month following the three months of Employer participation including the two consecutive months of contributions for Participant).

First full monthly contribution:	**First month of coverage will be:**
December	March
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February

You can also become eligible if the Fund has received nine (9) weeks of contributions within a 12-month period from a contributing employer. You must then satisfy an 8-week waiting period. Your effective date is the start of the 9th week following receipt of 9 weeks of contributions. The corresponding chart below reflects a participant's eligibility date based on the 9th weekly contribution.

Example: Employer's 9th week of contributions is the week ending 01/12/13. Participant's effective date is 03/10/13 (i.e., the start of the 9th week after receipt of 9 weeks of contributions).

TERMINATION/REINSTATEMENT OF COVERAGE

When an employer is not responsible to make contributions, coverage will actually be extended through the end of the 9th week immediately following the last full weekly contribution. You will then be given self-pay options to continue their coverage.

Example: Employer does not make contributions starting the week ending 01/12/13. Benefits will terminate midnight 03/09/13 (i.e., the end of the 9th week after the contributions ended).

If you return to work for a contributing employer within 24 months of the date on which your eligibility was terminated your coverage will be reinstated immediately following the end of the 9th week following your return to work (or the corresponding week two months ahead).

Example: Employer begins making contributions the week ending 01/12/13 for an employee returning from lay-off. Benefits will be reinstated 03/10/13 (i.e., the first day after the end of the 9th week of contributions).

The chart below illustrates the dates coverage initially starts (9th week beginning after 9 weeks of initial contributions), ends (week beginning after 9 weeks of no contributions) or resumes (week beginning after 9 weeks of resumed contributions):

If initial 9 weeks of contributions, Layoff, or Return to work, *occurs in the month of:*	**If Employer's 9th week of initial contributions, Employer stops contributions, or You return to covered employment (week ending):**	**Date coverage will begin, end or reinstate (week beginning):**
January 2013	1/5; 1/12; 1/19; 1/26	3/3; 3/10; 3/17; 3/24
February 2013	2/2; 2/9; 2/16; 2/23	3/31; 4/7; 4/14; 4/21
March 2013	3/2; 3/9; 3/16; 3/23; 3/30	4/28; 5/5; 5/12; 5/19; 5/26
April 2013	4/6; 4/13; 4/20; 4/27	6/2; 6/9; 6/16; 6/23
May 2013	5/4; 5/11; 5/18; 5/25	6/30; 7/7; 7/14; 7/21
June 2013	6/1; 6/8; 6/15; 6/22; 6/29	7/28; 8/4; 8/11; 8/18; 8/25
July 2013	7/6; 7/13; 7/20; 7/27	9/1; 9/8; 9/15; 9/22
August 2013	8/3; 8/10; 8/17; 8/24; 8/31	9/29; 10/6; 10/13; 10/20; 10/27
September 2013	9/7; 9/14; 9/21; 9/28	11/3; 11/10; 11/17; 11/24
October 2013	10/5; 10/12; 10/19; 10/26	12/1; 12/8; 12/15; 12/22
November 2013	11/2; 11/9; 11/16; 11/23; 11/30	12/29; 1/5/14; 1/12; 1/19; 1/26
December 2013	12/7; 12/14; 12/21; 12/28	2/2/14; 2/9; 2/16; 2/23
Weeks based on 2013 calendar (with some carryover to 2014) for example only **Assumes week ending day of Saturday and week beginning day of Sunday**		

CONTINUING ELIGIBILITY

In order to remain eligible for coverage for each month, your employer must make contributions for all weeks of that month. Otherwise, you must make self-contributions for coverage as described in the section on self-contributions.

SELF-CONTRIBUTION

You may continue your benefits in force for an additional period of two (2) months immediately following your termination date, if you pay in advance the contribution required by the collective bargaining agreement applicable to your employment. Payment must be made to the Fund Office by the date indicated on the continuation of coverage options notification and no later than within fifteen (15) days after the first of the month of which eligibility is available to you. The amount of payment required for these two months will be calculated at 50% of the current COBRA Rate. This limit of two consecutive months will be upon each unemployment period with no limit on the number of two-month periods.

As an example, let's assume you are laid off and your employer does not make contributions starting with the week ending January 12, 2013. Once your eligibility period ends at midnight on March 9, 2013, you will be entitled to pay the remainder of that month at the current employer rate or begin your self-payment period. At the end of your second month of self-payments, you will be entitled to continue your benefits through COBRA or, if eligible for the Retiree Plan, begin the retiree self-pay program. If you become re-employed and establish eligibility, you will become eligible again for the two-month self-pay period.

If you wish to continue eligibility for the Plan's medical benefits only, you will be notified by the Fund Office of your options and the cost of such coverage as soon as your employer has ceased to make contributions on your behalf. At the time of your termination of coverage you must elect the amount of coverage you wish to continue and you cannot change the coverage you elected during the self-contribution period.

This self-contribution privilege is not available to you if the reason that you are no longer insured is because your employer is no longer required to make contributions to the Fund. In other words, if your employer has left the Fund and is therefore no longer considered a contributing employer, you become ineligible to self-contribute to maintain benefits, unless the contributing employer left the Fund due to the permanent cessation of business, or unless you were already self-contributing at the time the employer terminated his contributions to the Fund.

TERMINATION

When you stop being an eligible person or do not pay the required contribution, coverage stops for all covered persons at the end of the period for which payment was made. Coverage stops for a Dependent on the date that person no longer meets the definition of Dependent.

You will stop being an eligible person upon the occurrence of any of the following:

- The date you enter the military;
- The date you cease to be a member in good standing with Teamsters Local Union No. 377;
- The end of the 9th week immediately following the last full weekly contribution received from your employer;
- The last day of the month for which you cease to make self-contributions;
- The Fund has the right to void the coverage of any covered person who engages in fraudulent conduct relating to claims or application for coverage, as determined by the Fund.

You are responsible for notifying the Plan of any of these above-mentioned terminating events.

CERTIFICATE OF CREDITABLE COVERAGE AVAILABLE AFTER YOU LOSE COVERAGE UNDER THIS PLAN

When you become covered under a new medical plan or another welfare plan or insurance policy that contains a pre-existing conditions provision, the exclusion period is reduced by your "creditable coverage." If you request (or authorize others to request) certification from this Plan within 24 months of the date your coverage terminated, the Plan will provide you with a certificate documenting the period of time you were covered by this Plan. Provided there is no more than a 63-day break in coverage, the time you were covered by this Plan may reduce the pre-existing conditions period under the new plan.

CHANGES IN COVERAGE

If you applied for individual coverage, you can change to family coverage if you marry or add a child. The date coverage is effective for a spouse or child depends upon when the Fund is notified, so tell us promptly. **Failure to promptly notify the Fund office about adding a spouse or child can result in a long delay in that person's eligibility for coverage.**

Family coverage should be changed to individual coverage when only the employee is eligible. In addition, the Fund should be notified when a covered person becomes eligible for Medicare.

DEPENDENT ELIGIBILITY

Your Dependents are:

- Your lawful wife or husband, unless you are divorced or legally separated:
- Your dependent children, step children, and adopted children through the end of the month of their 26th birthday regardless of marital status or the availability of other group health coverage through their employer;
- Your unmarried children who can't work to support themselves due to mental retardation or physical handicap. The disability must have started before the end of the month in which the child reaches the age limit when eligibility would otherwise have ended.

COVERAGE FOR INDIVIDUALS WHO RECEIVE A SOCIAL SECURITY DISABILITY AWARD

If you receive a social security disability award, you will be eligible to participate in the retiree program at the same premium rate and benefits as those retiring at age 55. There is no minimum age requirement for eligibility, so long as you have received a social security disability award.

SECTION 3
ELIGIBILITY
(FOR RETIREES AND THEIR FAMILIES)

This section tells how to apply for coverage, how and when you become eligible for coverage, who is considered a Dependent, and when your coverage starts. This section also explains when you should change from individual to family coverage and how you should apply for the change.

To enroll you must complete an application card, but no physical examination is required. You can enroll for either individual or family coverage. You will receive an identification card from Medical Mutual of Ohio, which shows your identification number. If you have family coverage, it is important for you to know which family members are eligible for benefits.

The following eligibility rules must be met in order for a Retiree **between the ages of 55 and 65** to qualify for Retiree Health Insurance Benefits. These benefits are being provided in part through current contributions being paid on behalf of active members covered under this Welfare Fund and direct Retiree contributions.

In order for a Retiree to be eligible for these benefits, it is necessary to meet the following requirements:

1. The Retiree must be at least age 55 and have been an eligible active employee under the Health and Welfare Fund for at least 9 full years of the 12 years immediately prior to his termination as an active employee on or after age 55. The Retiree must have been covered by this Health and Welfare Fund for a period of at least 2 full years as an active employee immediately prior to age 55, if previously covered by another Teamster Industry health insurance fund or employer paid plan negotiated with Teamsters Local 377.

2. The Retiree must have been in covered employment as an active employee for which contributions were paid under the Teamsters Central States Pension Fund, other teamster pension fund or Local No. 377 negotiated employer pension plan immediately prior to age 55, and earned sufficient credit to retire at that date or at a later date.

3. The Retiree must pay the required monthly contribution established by the Board of Trustees within the required time.

4. Retirees' monthly contribution shall be paid within fifteen (15) days following the first day of the month of which eligibility is available to the Retiree. If the required contribution is not paid by the 15th day of the month, the Retiree shall lose eligibility retroactive to the first day of the month. Payment is deemed received on the date submitted to the Fund office in person, or if by mail, on the date postmarked on the envelope.

Note: Spouses of individuals who retire after age 65 will be allowed to enter the retiree program so long as he/she meets the age requirements established in this Section.

For further information regarding retirement eligibility requirements please contact the Fund office.

COVERAGE FOR INDIVIDUALS WHO RECEIVE A SOCIAL SECURITY DISABILITY AWARD

If you receive a social security disability award, you will be eligible to participate in the retiree program at the same premium rate and benefits as those retiring at age 55. There is no minimum age requirement for eligibility, so long as you have received a social security disability award.

DEPENDENT ELIGIBILITY

Your Dependents are:

- Your wife or husband, unless you are divorced or legally separated:
- Your dependent children, step children, and adopted children through the end of the month of their 26th birthday regardless of marital status of the availability of other group health coverage through their employer;
- Your unmarried children who can't work to support themselves due to mental retardation or physical handicap. The disability must have started before the end of the month in which the child reaches the age limit when eligibility would otherwise have ended.

TERMINATION

When you stop being an eligible person or do not pay the required contribution, coverage stops for all covered persons at the end of the period for which payment was made. Coverage stops for a dependent on the date that person no longer meets the definition of dependent.

You will stop being an eligible person upon the occurrence of any of the following:

- For Retiree if Retiree becomes eligible or otherwise entitled to receive Medicare benefits;
- For Dependent if Dependent becomes eligible or otherwise entitled to receive Medicare benefits;
- The last day of the month for which you cease to make self-contributions;
- The Fund has the right to void the coverage of any covered person who engages in fraudulent conduct relating to claims or application for coverage, as determined by the Fund.

You are responsible for notifying the Plan of any of these above-mentioned terminating events.

In the event the Retiree or Dependent becomes eligible for Medicare prior to reaching age 65 due to disability, the Plan will provide secondary coverage only. Once the individual turns age 65 and becomes eligible for otherwise entitled to Medicare, coverage terminates.

CERTIFICATE OF CREDITABLE COVERAGE AVAILABLE AFTER YOU LOSE COVERAGE UNDER THIS PLAN

When you become covered under a new medical plan or another welfare plan or insurance policy that contains a pre-existing conditions provision, the exclusion period is reduced by your "creditable coverage." If you request (or authorize others to request) certification from this Plan within 24 months of the date your coverage terminated, the Plan will provide you with a certificate documenting the period of time you were covered by this Plan. Provided there is no more than a 63 day break in coverage, the time you were covered by this Plan may reduce the pre-existing conditions period under the new plan.

CHANGES IN COVERAGE

If you applied for individual coverage, you can change to family coverage if you marry or add a child. The date coverage is effective for a spouse or child depends upon when the Fund is notified, so tell us promptly. **Failure to promptly notify the Fund office about adding a spouse or child can result in a long delay in that person's eligibility for coverage. Family coverage should be changed to individual coverage when only the retiree is eligible.**

SPECIAL MATTERS

The purpose of providing these benefits is to enable the Retiree and his spouse to have adequate health coverage until he attains age 65. This coverage is not intended to be primary if the Retiree obtains employment which provides health insurance. If this occurs, it is required that the Retiree notify the Fund of this fact. The Fund will, upon notification that other coverage is available, suspend this coverage. It will be reinstated one the Retiree notifies the Fund that coverage is no longer available through his employment and he pays the required contribution to the Fund. If the Retiree fails to notify the Fund that he has other coverage, including Medicare, his right to continue in this Fund's coverage will be terminated. Please contact the Fund to receive the form, "Request to Discontinue Retiree Health Insurance Benefits Due to Other Group Health Coverage through Retiree or Spouse."

It is very important that you recognize the high cost of these benefits. If you have a working spouse who has available coverage it is required that she take such coverage for herself. It is not the intent of this Fund to relieve the spouse's employer of the responsibility for primary health insurance coverage to which she may be entitled by virtue of her employment. Failure to notify the Fund of this available coverage will result in your spouse's loss of coverage for the balance of the period which may be available to the Retiree.

SECTION 4
DEATH BENEFIT
(For Employees Only)

In the event of your death at any time or place while you are covered under the Fund, a self-funded death benefit in the amount indicated on the Summary of Benefits will be paid in a lump sum to the beneficiary you have named. However, no benefit will be paid for death by suicide. Please consult with a qualified tax advisor regarding any applicable tax consequences related to this benefit.

CLAIM PAYMENTS

If you have not named a beneficiary or if the beneficiary you have named is no longer living, the benefit amount will be paid to:

1. Your surviving spouse, if any,
2. Your surviving children equally, if there is no surviving spouse,
3. Your surviving parents equally, if there is no surviving spouse or children.
4. If none of the above survive you, no benefit will be paid.

CLAIM FILING FOR BENEFITS

All claims for the Death Benefit must be filed through the Fund Office.

All claims should be filed as soon as possible. Death Benefit claims must be filed within one year of the date of loss. The beneficiary of the Participant should bring a certified copy of the Death Certificate to the Fund Office.

YOU MAY CHANGE YOUR BENEFICIARY WHENEVER YOU WISH BY COMPLETING THE APPROPRIATE FORM AVAILABLE AT THE FUND OFFICE. YOU MUST DO THIS IN PERSON.

Should you die within thirty one (31) days after your eligibility ends, the death benefit will be paid just as if you were eligible at the time of your death.

If prior to age sixty (60) you become totally and permanently disabled, your Death Benefit will continue without cost for a period of twelve (12) months. Proof of total and permanent disability must be presented within the twelve-month period, and yearly thereafter, to continue the Death Benefit in force.

Because of the self-insured status of the Fund, this Death Benefit cannot be converted to individual coverage.

The Fund is not obligated to notify you or your beneficiary of any termination of coverage.

EXCLUSIONS TO DEATH BENEFIT

Benefits shall not be payable for any death due to:

1) Self-destruction or any self-inflicted death while sane or insane. Including any intentional abuse or misuse of any drug, alcohol, poison or fumes taken or inhaled, or

2) Insurrection, participation in a riot, police duty as a member of any military organization, war or any act of war declared or undeclared, or

3) Participation in or as the result of the commission of a criminal or otherwise unlawful act.

SECTION 5
DEATH BENEFIT
(For Retirees Only)

In the event of your death at any time or place while you are covered under the Fund, a self-funded death benefit in the amount indicated on the Summary of Benefits (i.e., $2,000) will be paid in a lump sum to the beneficiary you have named. However, no benefit will be paid for death by suicide.

CLAIM PAYMENTS

If you have not named a beneficiary or if the beneficiary you have named is no longer living, the benefit amount will be paid to:

1. Your surviving spouse, if any,
2. Your surviving children equally, if there is no surviving spouse,
3. Your surviving parents equally, if there is no surviving spouse or children.
4. If none of the above survive you, no benefit will be paid.

CLAIM FILING FOR BENEFITS

All claims for the Death Benefit must be filed through the Fund Office.

All claims should be filed as soon as possible. Death Benefit claims must be filed within one year of the date of loss. The beneficiary of the Retiree should bring a certified copy of the Death Certificate to the Fund Office.

YOU MAY CHANGE YOUR BENEFICIARY WHENEVER YOU WISH BY COMPLETING THE APPROPRIATE FORM AVAILABLE AT THE FUND OFFICE. YOU MUST DO THIS IN PERSON.

Should you die within thirty one (31) days after your eligibility ends, the death benefit will be paid just as if you were eligible at the time of your death.

If prior to age sixty (60) you become totally and permanently disabled, your Death Benefit will continue without cost for a period of twelve (12) months. Proof of total and permanent disability must be presented within the twelve-month period, and yearly thereafter, to continue the Death Benefit in force. Because of the self-insured status of the Fund, this Death Benefit cannot be converted to individual coverage. The Fund is not obligated to notify you or your beneficiary of any termination of coverage.

EXCLUSIONS TO DEATH BENEFIT

Benefits shall not be payable for any death due to:

1) Self-destruction or any self-inflicted death while sane or insane. Including any intentional abuse or misuse of any drug, alcohol, poison or fumes taken or inhaled, or

2) Insurrection, participation in a riot, police duty as a member of any military organization, war or any act of war declared or undeclared, or

3) Participation in or as the result of the commission of a criminal or otherwise unlawful act.

SECTION 6
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
(For Employees Only)

If you are involved in an accident on or off the job which results in loss of life, loss of limbs or loss of sight within ninety (90) days following the accident, and the accident occurs while you are eligible for benefits, a benefit in the amount indicated in the Summary of Benefits is payable in addition to the Death Benefit.

If you die, the benefit will be paid to your beneficiary in the same manner as your Death Benefit. In the event of dismemberment, the benefit will be paid to you.

No payment will be made for losses resulting from suicide or any attempt at suicide, or as a result of committing or attempting to commit a felony.

Depending on the extent of the loss, the following benefits are payable:

Benefit	*Maximum Payable*
Loss of Life	Full Amount
Both hands or both feet, or sight of both eyes	Full Amount
Any combination of foot, hand, or sight of one eye	Full Amount
One hand, one foot or sight of one eye	1 / 2 Full Amount

CLAIM PAYMENTS

ACCIDENTAL DEATH BENEFIT

This benefit will be paid the same as your Death Benefit. The Fund has the right to have an autopsy conducted in connection with a claim for accidental death.

DISMEMBERMENT BENEFIT

Benefits will be paid to you immediately after the Fund receives satisfactory proof of loss. The Fund has the right to require an examination in connection with a claim for dismemberment.

CLAIM FILING FOR BENEFITS

All claims for benefits described in this section must be filed through the Fund Office.

All claims should be filed as soon as possible. Accidental Death and Dismemberment claims must be filed within one year of the date of loss. The beneficiary of the Participant should bring a certified copy of the Death Certificate to the Fund Office.

EXCLUSIONS TO ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Benefits shall not be payable for any death/loss due to:

1) Self-destruction or any self-inflicted injury / death while sane or insane. Including any intentional abuse or misuse of any drug, alcohol, poison or fumes taken or inhaled, or

2) Insurrection, participation in a riot, police duty as a member of any military organization, war or any act of war declared or undeclared, or

3) Participation in or as the result of the commission of a criminal or otherwise unlawful act, or

4) Disease, bodily or mental illness, or medical or surgical treatment. (Accidental Death and Dismemberment Benefit only.)

SECTION 7
WEEKLY DISABILITY BENEFIT
(For Employees Only)

This benefit is payable as a wage replacement if you become totally disabled and cannot work due to either an accidental bodily injury or a sickness, not connected with your employment. You must be under the regular and direct care of a licensed physician or surgeon who certifies that you are totally disabled. Benefit payments will begin with the first (1st) day of disability in the event of an accident or the eighth (8th) consecutive day in the event of sickness, but will not be paid for more than twenty six (26) weeks for each period of disability.

Successive periods of disability will be considered as one continuous period of disability if they are due to the same or related causes and are not separated by a return to active work for at least six (6) weeks. However, if you return to active work for at least six weeks between periods of disability which are due to the same or related causes, or if the periods of disability are separated by return to active work and are due to different and unrelated causes, then each disability will be considered separately, and benefits will be payable up to 26 weeks for each disability.

Your right to continue to receive weekly disability benefit ends when your Employer no longer makes health and welfare contributions to the Health and Welfare Fund because its Collective Bargaining Agreement with Teamsters Local No. 377 no longer requires the Employer to contribute to the Fund.

EXCLUSIONS FOR WEEKLY DISABILITY BENEFITS

Disabilities not covered are those for any period that you are entitled to primary benefits under the Federal Social Security Act and amendments thereto.

Disabilities not covered are those that result from attempted suicide or self-inflicted injury or illness, injury sustained during or as a result of the commission, or attempt to commit a criminal act, as determined by the Board of Trustees.

Any benefits paid by the Plan which are also covered by Workers Compensation laws entitles the Fund to full reimbursement, as provided in the Subrogation section of this document. Furthermore, if an accident or sickness is related to your employment, and is compensable under state Workers Compensation laws or similar laws, any resulting expenses and/or benefits are excluded from payment by this Plan.

SECTION 8
HOSPITAL SERVICES

You have the advantages of lower costs for medical care when you use network facilities and providers and the flexibility to use non-network facilities and providers if you wish. The Summary of Benefits schedule shows you how benefits are actually paid for both network and non-network facilities and providers.

You are responsible for certain costs of the coverage. For example, as shown on the Summary of Benefits, network charges are paid at 80% and non-network charges at 60%. This means that you must pay either 20% (if network) or 40% (if non-network) of the cost, with an out-of pocket maximum coinsurance payable by you each Benefit Period of $5,000 if single or $10,000 if family coverage. In addition, you must also satisfy the Benefit Period deductible which is $500 if single, or $1,000 if family, for network charges. If the charges are non-network, the deductibles increase to $1,000/$2,000.

In addition, if you use a non-contracting provider, you are responsible for paying the difference between the Allowed Amount and the provider's charge.

UTILIZATION REVIEW

Inpatient admissions to a Hospital must be precertified. The telephone number for precertification is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this precertification is done; and since the Hospital is responsible for obtaining the precertification, there is no penalty to you if this is not done. For Non-Contracting or Out of State Hospitals, you are responsible for obtaining precertification. If you do not precertify a Hospital admission and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges. However, if your Inpatient stay is for an organ transplant, please review the requirements under the Organ and Tissue Transplant Services section.

HOSPITAL EXPENSE BENEFIT

If you are hospitalized because of an illness, injury or pregnancy, the Hospital Expense Benefit covers the hospital bill for your room and board and for miscellaneous expenses related to treatment you receive while you are an inpatient in the hospital.

Covered Expenses Include:

1) Room and board in a semi-private room, an intensive care unit, coronary care unit, burn unit or isolation room, if medically required. If no rate for a semi-private room is available at the hospital where you are confined, the Plan will pay a rate based on the average charge for a semi-private room in the surrounding area.

NOTE: **If you choose to stay in a private room you must pay the difference** between the private and the semi-private room rate. If you are put into a private room because you are contagious to other patients, the private room rate will be paid.

2) Miscellaneous expenses such as medicines, laboratory tests, X-rays, oxygen, anesthesia and other similar services are provided for you in a hospital.

The Plan will pay 80% of Negotiated Rate, after the deductible has been met, for the length of the hospital confinement.

Services Not Covered By This Benefit:

1) Personal comfort items, such as hair appointments, magazines, telephone or television service in your room.

2) All taxes and surcharges.

3) Difference between private and semi-private room rate.

On-Line Certification For Hospitals

The Fund has an on-line certification system through Medical Mutual of Ohio, which is available to contracting hospitals. Your identification card information will allow contracting providers to electronically submit bills to speed up the claim payment process.

SURGICAL EXPENSE BENEFIT FOR HOSPITAL SERVICES ONLY

The Surgical Expense Benefit covers surgery services billed by a hospital. In addition, coverage is provided for the following specified services:

- sterilization, regardless of medical necessity
- removal of bony impacted teeth;
- surgery to correct deformity caused by disease, trauma, birth defects, growth defects or prior therapeutic processes; and
- surgery to improve a functional deficiency.

Services Not Covered By This Benefit:

1) Surgical procedures which are performed for cosmetic reasons are not covered unless as a result of an accidental injury.

Examples of cosmetic surgery include, but are not limited to:

a) For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal, unless determined by Medical Mutual to be a Covered Service in accordance with Medical Mutual's corporate medical policy. Otherwise, services for obesity are paid at 80% after deductible network / 60% after deductible non-network. Surgical services for weight loss, including complications from weight loss surgical services, are paid based on services rendered.

b) Reduction Mammoplasty – (breast reduction surgery).

c) Augmentation Mammoplasty – (breast enlargement surgery), unless part of reconstruction following breast surgery due to cancer.

d) Rhinoplasty – (plastic surgery on the nose) unless the result of an accident or chronic nasal obstruction.

e) Otoplasty – (plastic surgery on ears).

f) Blepharoplast – (repair of drooping eyelids) unless the droop restricts field of vision as verified by an ophthalmologist.

g) Keratectomy – for diagnosis of Myopia (near-sightedness) when Myopia is correctable by lenses.

h) Rhytidectomy – (face lift)

i) Dyschromia – (tattoo removal)

j) Panniculectomy – sometimes called "tummy-tuck"

k) Genioplasty – (chin augmentation)

2) If you have two separate operations, the Plan will consider the charge for each operation. If however, you have two surgical procedures performed through the same incision or body opening, the Plan will only consider the procedure with the highest reasonable charge limitation.

3) Charges for care, treatment, services and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care; including care, treatment, services and supplies which are experimental in nature.

4) Reversal of sterilization procedures.

EMERGENCY ACCIDENT/ILLNESS BENEFIT

This benefit covers treatment you receive in an emergency room due to an accidental injury and medical emergency. After you pay the $100 copay, the Plan will pay 80% after deductible for services under this benefit if, without immediate care, the injury or illness could:

- permanently endanger your health;
- cause other serious conditions;
- seriously impair your body functions; or
- cause serious and permanent damage to any part of your body.

Services Not Covered By This Benefit:

Charges for the emergency treatment of an illness and/or injury that do not meet the definition of emergency care, as defined herein, are not covered under the Medical Emergency Benefit.

Portions of an expense paid under another benefit of this Plan.

Charges in connection with a surgical procedure.

NON-EMERGENCY ACCIDENT/ILLNESS BENEFIT

When you receive medical treatment in an emergency room due to a sudden or unexpected medical condition that is not life or limb threatening. Services for this benefit will be paid according to the Summary of Benefits schedule located at the beginning of this booklet.

OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY EXPENSE BENEFIT

Diagnostic Services Include:

- Radiology, ultrasound and nuclear medicine.

- Laboratory and pathology services, when provided on an outpatient basis.
- EKG, EEG and other electronic diagnostic medical procedures.

Diagnostic Services rendered other than at a Physician's office are paid at 80% after the deductible is satisfied.

The Outpatient Diagnostic X-ray and Laboratory Expense Benefit covers charges for X-Ray and/or Laboratory work done at your Physician's request, on an outpatient basis, because of illness, injury or pregnancy. The Plan will pay 80% of the Negotiated Rate after deductible for X-Ray and/or Laboratory procedures, including the related physician's visit when performed by a network provider. Outpatient diagnostic services at other than a physician's office are paid at 80% after deductible.

Services Not Covered By This Benefit:

Routine dental X-Rays and laboratory work.

SKILLED NURSING FACILITY BENEFIT

Benefits will be payable for charges incurred for Skilled Nursing Care if services are performed in a Skilled Nursing Facility (SNF) and can only be performed by, or under the supervision of, licensed nursing personnel. The care in a SNF includes room and board charges, registered nursing services, physical therapy, drugs, supplies and equipment.

Services are not covered unless you or your dependents have spent at least three (3) consecutive days in a hospital for a related condition, prior to your transfer to the SNF. Medicare coverage is limited to one hundred (100) days of inpatient care in the SNF for the same spell of illness. The services in the SNF must be skilled nursing services and not custodial care. Medicare payment is reduced by a coinsurance that the patient must pay after the 20th day of covered SNF care.

In determining whether these services are required under the extended care benefit, three (3) criteria must be met:

1) Skilled Nursing Services or Skilled Rehabilitation Services must be required on a daily basis;
2) Services must be furnished for a condition for which the beneficiary received inpatient hospital services or which arose while he/she was receiving care in an SNF for such a condition;
3) Service can only be provided in a Skilled Nursing Facility on an inpatient basis.

Skilled Nursing and/or Skilled Rehabilitation Services are those furnished by request of your primary care physician's orders which:

1) Require skills of technical or professional personnel, e.g., registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist, or audiologist;
2) Are provided by directly or under the supervision of such personnel.

HOME HEALTH CARE BENEFIT

The following are Covered Services when you receive them in your home, from a Hospital or a Home Health Care Agency:

- professional services of a registered or licensed practical nurse;
- treatment by physical means, occupational therapy and speech therapy;
- medical and surgical supplies;
- Prescription Drugs;
- oxygen and its administration;
- medical social services, such as the counseling of patients; and
- home health aide visits when you are also receiving covered nursing or therapy services.

The Plan will not cover any home health care services or supplies which are not specifically listed in this Home Health Care Services section. Examples include but are not limited to:

- homemaker services;
- food or home delivered meals; and
- Custodial Care, rest care or care which is only for someone's convenience.

All Home Health Care services must be certified initially by your Physician and your Physician must continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Plan. All services will be provided according to your Physician's treatment plan and as authorized as Medically Necessary by Medical Mutual.

HOSPICE CARE BENEFIT

A Participant who is eligible for regular Plan benefits will be eligible for Hospice Care benefits if certified by a physician to have a life expectancy of six (6) months or less.

The eligible person must submit an election statement to the Fund Office choosing Hospice Care in lieu of all other Plan benefits. However, expenses for any illness or injury which is not related to the terminal illness will be covered under regular Plan benefits.

A treatment plan must be developed and submitted for approval by the Participant's physician and the provider of the Hospice Care services. All covered services must be provided by a licensed Hospice organization or a Hospice program sponsored by a Hospital or Home Healthcare Agency.

The Fund will pay for the following services, up to the amount of the allowance permitted for Hospice Care by the federal Medicare law in the geographic area in which the Hospice is located:

- Acute inpatient Hospice Care
- Respite care
- Dietary guidance
- Durable medical equipment
- Home Health Aide visits
- Bereavement counseling for family members, limited to two visits

Approved Prescription Drugs will be limited to a 34-day supply per Prescription Order or Refill. These Prescription Drugs must be required for supportive care.

<u>Exclusions under this benefit include:</u>

- Volunteer services

- Spiritual counseling
- Homemaker services
- Food or home delivered meals
- Chemotherapy or radiation therapy if other than to relieve symptoms of a condition
- Custodial care, rest care or care which is only for someone's convenience

AMBULANCE SERVICE HOSPITAL BENEFIT

The Plan will pay for licensed ambulance services as listed in the Summary of Benefits, to transport an individual to and from a hospital for medical treatment only.

Services Not Covered By This Benefit

- Transportation in any privately owned vehicle.
- Services and supplies which the covered individual is not legally required to pay.
- Transportation for reasons other than receiving needed medical treatment.
- Transportation to receive medical treatment which is available at the current location.
- Transportation services provided by an ambulette or a wheelchair van.

ORGAN TRANSPLANT SERVICES

This benefit covers charges for medical treatment received for the donation of an organ. The transplant program must be approved through the predetermination program and all covered services must medically necessary.

Your coverage includes benefits for the following human organ transplants:

heart;

lung;

heart and lung;

liver;

bone marrow;

pancreas and pancreas/kidney;

kidney; and

cornea

Donor organ/tissue and donor benefits:

The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ/tissue:

- evaluation of the organ/tissue;
- removal of the organ/tissue from the donor; and
- transportation of the organ/tissue to the Transplant Center.

Benefits necessary for obtaining an organ/tissue from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post-operative complications if Medically Necessary as determined by Medical Mutual. Such coverage is available only so long as the recipient's coverage is in effect.

The Plan does not provide organ/tissue transplant benefits for services, supplies or Charges:

- which are not furnished through a course of treatment which has been approved by Medical Mutual;
- for other than a legally obtained human organ/tissue;
- for travel time and the travel-related expenses of a Provider;
- that are related to other than human organ/tissue.

These services will be covered if they are provided during the transplant benefit period. A transplant benefit period is a period of time which starts five days before the day you receive your first covered transplant and ends 12 months later. A new transplant benefit period starts only when the next covered transplant occurs 12 months after the last covered transplant was performed.

Organ Transplant Pre-Certification

In order for an Organ Transplant to be a covered service, the proposed course of treatment must be pre-certified and approved by Medical Mutual of Ohio. No benefits will be paid for Organ Transplant Services which have not been pre-certified.

After your physician has examined you, he must provide Medical Mutual with:

1. The proposed course of treatment for the transplant program;
2. The name and location of the proposed Transplant; and
3. Copies of your medical records, including diagnostic reports for Medical Mutual to determine the suitability and medical necessity of the transplant services.

This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ.

You may also be required to undergo an examination by a physician chosen by Medical Mutual. You and your physician will then be notified.

If the donor and the recipient of the organ are both covered under a plan, each individual will receive the available benefits under their respective plans.

If the recipient is covered under this Plan and the organ donor is not, all charges for the organ transplant services related to the removal of the donor organ will be paid as if the donor is covered under this Plan.

DURABLE MEDICAL EQUIPMENT (Hospital Charges Only)

Supplies and equipment are covered under this benefit when prescribed by your physician and billed by the hospital. The supplies and equipment must serve a specific, therapeutic purpose in the treatment of a condition. Your physician must provide a written treatment plan that shows how the prescribed equipment is medically necessary for the diagnosis and treatment or how it will improve a specific body function.

The Plan will pay 80% of negotiated Rate for these supplies, after the deductible is met, when utilized by a network hospital or network provider. **If you choose to receive services from a provider who is not in the network with Medical Mutual of Ohio, the claim will be paid based on the Summary of Benefits located at the beginning of this book.**

INPATIENT PSYCHIATRIC BENEFIT

This benefit covers treatment of psychiatric related conditions. The following services are payable for treatment:

- Individual psychotherapy
- Group psychotherapy
- Electroshock therapy and related anesthesia only if given in a hospital or psychiatric hospital.
- Psychological testing, limited to one battery of tests per covered person per calendar year.

Services extended beyond the time necessary to evaluate or diagnose mental deficiency or retardation are not covered.

Inpatient care rendered outside the state of Ohio must be pre-approved prior to admission.

If you are being treated by a network psychiatrist or licensed psychologist, in a psychiatric treatment facility or alcoholism or drug abuse treatment facility, the Plan will pay for services listed in the Summary of Benefits.

Services excluded under the benefits for mental health, drug abuse and alcoholism treatment (outpatient services) include:

- Treatment not prescribed and performed by a physician or licensed psychologist.
- Legal services, recreational, vocational, financial or education counseling, except as part of a chemical dependency treatment program.
- Detoxification or drug withdrawal programs not rendered by a hospital or as part of a maintenance program.
- Personal comfort items.
- Marriage or family counseling except as part of a psychiatric treatment program.
- Charges for services provided by a Social Worker.
- Others licensed by the state, under supervision of an MD.
- Autism, developmental delay, and mental retardation.

Services obtained from a physician, hospital or other professional provider who is not a Medical Mutual network physician or network hospital will be subject to the deductible and co-pay according to the Summary of Benefits. You will be responsible for any difference between the amount the Plan pays and the provider's normal charge, when you go to non-contracting non-network provider. The Plan and Medical Mutual reserve the right to limit the amount paid for covered services to a non-contracting provider.

INPATIENT SUBSTANCE ABUSE BENEFIT

This service covers the treatment of drug abuse and alcohol related conditions. The following services are payable for treatment.

- Detoxification and rehabilitation services provided for the treatment of drug abuse or alcoholism.

Inpatient care rendered both inside and outside the state of Ohio must be pre-approved prior to admission.

If you are being treated by a network physician in a network treatment facility or alcoholism or drug abuse treatment facility, the Plan will pay 80% of the Negotiated Rate, after the deductible is met.

Services excluded under the benefits for drug abuse and alcoholism treatment include:

- Treatment not prescribed and performed by a licensed physician,
- Legal services, recreational, vocational, financial or educational counseling, except as part of a chemical dependency treatment program.
- Detoxification or drug withdrawal programs not rendered by a hospital or as part of a maintenance program.
- Personal comfort items.
- Marriage or family counseling except as part of psychiatric treatment program.
- Residential care rendered by a Residential Treatment Facility.

Services obtained from a physician, hospital or other professional provider, who is **not** a Medical Mutual network physician or network hospital, will be subject to the deductible and co-pay according to the rates in the Summary of Benefits. The Plan and Medical Mutual reserve the right to limit the amount paid for covered services to a non-contracting provider.

SECTION 9
PROFESSIONAL SERVICES

You have the advantages of lower costs for medical care when you use network providers and the flexibility to use non-network providers if you wish. The Summary of Benefits schedule shows you how benefits are actually paid for both network and non-network providers.

You are responsible for certain costs of the coverage. For example, as shown on the Summary of Benefits, network charges are paid at 80% and non-network charges at 60%. This means that you must pay either 20% (if network) or 40% (if non-network) of the cost, with an out-of pocket maximum coinsurance payable by you each Benefit Period of $5,000 if single or $10,000 if family coverage. In addition, you must also satisfy the Benefit Period deductible which is $500 if single, or $1,000 if family, for network charges. If the charges are non-network, the deductibles increase to $1,000/$2,000.

In addition, if you use a non-contracting provider, you are responsible for paying the difference between the Allowed Amount and the provider's charge.

IMPORTANT

As long as you utilize a Medical Mutual contracting provider, your total out-of-pocket expense will not exceed the total of your annual deductible amount plus the maximum coinsurance amount, regardless of whether you choose a network provider or non-network provider, as indicated in the Summary of Benefits schedule.

INPATIENT MEDICAL VISITS

Services are covered under this benefit when a covered person receives care by a licensed physician or other licensed provider, as a registered bed patient in a hospital or other provider facility where a room and board charge is made.

INPATIENT CONSULTATIONS

Bedside examinations by another licensed physician or other professional provider is covered when requested by your attending physician.

Staff consultations required by Hospital rules are not covered.

SURGERY BENEFIT
(INPATIENT OR OUTPATIENT PROFESSIONAL SERVICES)

The surgery benefit covers the physician's bill for surgery performed in a hospital, qualified outpatient surgical facility or a physician's office, as indicated in the Summary of Benefits schedule. The surgery must be the result of illness, injury or pregnancy. In addition, coverage is provided for the following specified services:

- sterilization, regardless of medical necessity;
- removal of bony impacted teeth;
- surgery to correct deformity caused by disease, trauma, birth defect, growth defects or prior therapeutic processes;
- surgery to improve a functional deficiency;

- Therapeutic and elective abortions;
- Maxillary or mandibular frenectomy;
- Diagnostic endoscopic procedures (colonoscopy & sigmoidoscopy);
- Reconstructive surgery following a mastectomy.

Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.

ANESTHESIA BENEFIT

Anesthesia coverage includes the administration of anesthesia, performed in connection with a covered service, by a licensed physician, other professional provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration.

Services of a stand-by anesthesiologist are only covered during coronary angioplasty surgery.

ASSISTANT AT SURGERY

Coverage for another licensed physician's help to your surgeon in performing covered surgery, when a hospital staff member, intern or resident is not available.

EMERGENCY ACCIDENT/ILLNESS BENEFIT

You are covered for emergency accident/illness care when treated by a licensed physician or other professional provider. These services include medical treatment that if not given immediate care, the condition could permanently endanger your health; cause other serious conditions; seriously impair your body functions; or cause serious and permanent damage to any part of your body.

AMBULANCE SERVICE BENEFIT

The Plan will pay 80% (Network) or 60% (Non-Network) for professional licensed ambulance service under this benefit, once the deductible has been met. Non-emergency ambulance use is not covered.

The Ambulance Service Benefit covers transportation charges for professional licensed ambulance service that is needed only for medical treatment. In addition, the Reasonable Charges for air ambulance services will also be covered, provided all the following conditions are met:

- The transportation is by a vehicle designed and equipped and used only to transport the sick and injured.
- The transportation is from the scene of an accident or medical emergency to a hospital or between hospitals.
- The trip is to the closest facility that can give the appropriate services for the condition.
- Certification by an attending physician must be received indicating that transportation using ground facilities would not have been appropriate due to the life threatening and emergency nature of the accident or illness.

NON-EMERGENCY ACCIDENT/ILLNESS BENEFIT

When you receive medical treatment in an emergency room due to a sudden or unexpected medical condition that is not life or limb threatening. Non-emergency use of an emergency room is not covered and the emergency room Physician charges are not covered.

MATERNITY AND ABORTION BENEFIT

Medical and surgical services for a normal pregnancy, complications of pregnancy and miscarriage are covered. Therapeutic and elective abortions are also covered services. (Excludes Dependent children).

INITIAL NEWBORN EXAM

Coverage includes the inpatient medical care visits to examine a newborn.

HOME AND OFFICE CALLS

Coverage includes evaluation and management services provided in a physician's office or in an outpatient or an ambulatory facility.

ADULT ROUTINE PHYSICAL EXAMS

An annual routine physical exam is covered under this benefit up to the allowable maximum amount.

ALLERGY TESTS AND TREATMENTS

Allergy tests which are performed and related to a specific diagnosis are covered services.

IMMUNIZATIONS

The following immunizations are covered under this benefit:

- tetanus toxoid
- other preventative vaccines.

ROUTINE PAP SMEAR, CHEST X-RAY, SMA12, CBC, URINALYSIS, MAMOGRAM AND EKG

These routine services are covered under this benefit, once per year.

WELL CHILD VISITS AND IMMUNIZATIONS

Regardless of medical necessity, coverage for child health supervision services will be provided for eligible dependent children up to the age of 21. The services will be paid up to the maximum amount established in the Summary of Benefits schedule.

DIAGNOSTIC SERVICES, RADIOLOGY, PATHOLOGY AND ALLERGY TESTING

A diagnostic service is a test or procedure performed by a licensed physician or other professional provider, when you have specific symptoms, to detect or monitor your condition. Covered services are limited to the following:

- radiology, ultrasound and nuclear medicine;
- laboratory and pathology services; and
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

THERAPY SERVICES (INPATIENT AND OUTPATIENT)

Coverage for therapy services and supplies used to promote recovery from a condition will be paid according to the Summary of Benefits schedule. Therapy services must be ordered by a licensed physician or other professional provider to be covered.

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Cardiac Rehabilitation

SKILLED NURSING FACILITY (MEDICAL VISITS)

These services must be skilled care and authorized and provided according to your physician's plan of treatment. Your physician must certify initially and every two weeks, thereafter, that you or your eligible Dependent is receiving skilled care and not custodial care.

No benefits will be provided:

- once a patient can no longer significantly improve from treatment for the current condition unless it is determined to be medically necessary.
- for custodial care, rest care or care which is only for someone's convenience; and
- for the treatment of mental illness, drug abuse or alcoholism.

DURABLE MEDICAL EQUIPMENT

Supplies and equipment are covered under this benefit when prescribed by your physician. The supplies and equipment must serve a specific, therapeutic purpose in the treatment of a condition. Your physician must provide a written treatment plan that shows how the prescribed equipment is medically necessary for the diagnosis and treatment or how it will improve a specific body function.

You may rent or purchase Durable Medical Equipment ("DME"); however, for each Condition, the Plan will not cover more in total rental costs than the customary purchase price as determined by Medical Mutual. For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of durable medical equipment.
When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME.

Covered DME includes:
- blood glucose monitors;
- crutches;
- home dialysis equipment;
- hospital beds;
- mastectomy bra;
- respirators;
- wheelchairs.

Non-covered equipment includes but is not limited to:
- rental costs if you are in a facility which provides such equipment;
- repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;
- Physician's equipment, such as a blood pressure cuff or stethoscope;
- deluxe equipment such as specially designed wheelchairs for use in sporting events;
- items not primarily medical in nature such as:
  an exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;
- items for comfort and convenience;
- disposable supplies and hygienic equipment;
- self-help devices such as: bedboards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units.

Orthotic Devices - Rigid or semirigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. These devices include:
- braces for the leg, arm, neck or back;
- trusses;
- back and special surgical corsets;

Non-covered devices include but are not limited to:
- garter belts, arch supports, corsets and corn and bunion pads;
- corrective shoes, except with accompanying orthopedic braces;
- arch supports and other foot care or foot support devices only to improve comfort or appearance. These include but are not limited to care for flat feet and subluxations, corns, bunions, calluses and toenails.

Prosthetic Appliances - Your coverage includes the purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:
- replace all or part of a missing body organ or limb and its adjoining tissues; or
- replace all or part of the function of a permanently useless or malfunctioning body organ or limb.

Covered prosthetic appliances include:
• artificial hands, arms, feet, legs and eyes, including permanent lenses;
• appliances needed to effectively use artificial limbs or corrective braces.

Non-covered appliances include but are not limited to:
• dentures, unless as a necessary part of a covered prosthesis;
• dental appliances;
• eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;
• replacement of cataract lenses unless needed because of a lens prescription change;
• taxes included in the purchase of a covered prosthetic appliance;
• deluxe prosthetics that are specially designed for uses such as sporting events;
• wigs and hair pieces.

OUTPATIENT PSYCHIATRIC AND SUBSTANCE ABUSE BENEFIT

The following are covered services for the treatment of psychiatric care by your licensed physician or other professional provider.

- individual and group psychotherapy;
- electroshock therapy and related anesthesia;
- psychological testing;
- family counseling

Detoxification and rehabilitation services are provided for the treatment of drug abuse or alcoholism. In addition, the following services are also covered for the treatment of drug abuse or alcoholism:

- individual and group psychotherapy;
- psychological testing; and
- family counseling

Your physician or other professional provider must certify that there is a reasonable likelihood that the treatment will be of substantial benefit and improvement likely.

DENTAL SERVICES FOR AN ACCIDENTAL INJURY

Dental services will only be covered when due to an accidental injury. The accidental injury must have caused damage to the jaws, sound natural teeth, mouth or face. The injury must have occurred on or after your effective date. Dental services must begin within one year from the date of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury.

- **A SUPERMED Plus provider should be used for the surgical extraction of bony impacted wisdom teeth and for dental services for an accidental injury. Claims should be filed with Medical Mutual of Ohio under your medical, surgical or accidental injury benefit. Failure to use a SUPERMED Plus provider could cause a substantial balance to you with regards to the difference between billed charges and Medical Mutual of Ohio's Allowed Amount.**

SMOKING CESSATION SERVICES

For Covered Persons age 18 and over, benefits are provided for the screening of tobacco use and for smoking cessation programs for those Covered Persons using tobacco to the extent required under the PPACA.

URGENT CARE SERVICES

Health problems that require immediate attention which are not Emergency Medical Conditions are considered to be Urgent Care needs. Determination as to whether or not Urgent Care Services are Medically Necessary will be made by Medical Mutual.

Examples of Urgent Care are:
- minor cuts and lacerations;
- minor burns;
- sprains;
- severe earaches or stomachaches;
- minor bone fractures; or
- minor injuries

SECTION 10
COMBINED DENTAL AND VISION SERVICE BENEFIT
(FOR EMPLOYEES AND THEIR FAMILIES ONLY)

The following benefits are available to Employees and their eligible Dependents covered under the Plan:

The Fund will consider all dental and vision services with no restrictions on frequency or covered procedures provided by a licensed Dentist, Physician or Vision Supplier up to the maximum allowance stated in the schedule of benefits.

Example:

Service	Total Cost	Benefit payment @ 80%	Your cost @ 20%	Combined annual benefit remaining
Eye exam, lenses, frames, contact fitting & contacts.	$ 400.00	$ 320.00	$ 80.00	$ 680.00
Dental exam, cleaning & x-rays	$ 100.00	$ 80.00	$ 20.00	$ 600.00
Major dental procedure i.e. crown, bridge, root canal	$ 750.00	$ 600.00	$ 150.00	$ 0.00
	$ 1,250.00	$ 1,000.00 **Maximum payable by Plan**	$ 250.00	
****ANY ADDITIONAL SERVICES INCURRED DURING THE CALENDAR YEAR FOR YOU OR ANY DEPENDENTS WILL BE YOUR RESPONSIBILITY****				

Special prescription lenses or contact lenses, which are required to correct cataract surgery, and extensive eye examinations by an ophthalmologist because of a disease of the eye, are covered separately under the major medical benefit.

Eligibility rules for dental and vision benefits are the same as those for other benefits under the Plan. Benefits will be paid only for services, which are performed while the covered person is eligible.

ORTHODONTIC SERVICES

Orthodontic services will be covered for all eligible Participants and their Dependents up to a maximum Lifetime benefit of $1,000.

CLAIM PROCEDURES

To file a claim for vision or dental benefits, you should request a claim form from the Fund Office. This form must be completed by the Participant and by the provider of the services. Originals or copies of all relevant bills or receipts, showing the type of service performed, the name and address of the provider, and an itemized statement of cost, must be attached to the form and submitted to the Fund Office. The claim form and all supporting documentation must be filed within ninety (90) days of the date of service.

Benefits are not provided for services that exceed the annual maximum allowance under this benefit.

SECTION 11
PRESCRIPTION DRUG BENEFIT

This benefit is administered by Express Scripts, Inc. (ESI). You will be issued plastic identification card or cards directly from ESI. Please review the information on the card for any discrepancies, report them to the Fund office.

Your card is not transferable and remains the property of ESI. Improper or fraudulent use of this card to obtain prescription drugs is punishable by law. This card is void when your eligibility is terminated. The loss of your card should be reported immediately to the Fund Office.

You can use your card at any ESI participating pharmacy. Should you have any questions regarding participating pharmacies please contact ESI's toll free pharmacy locator number at 1-800-887-1044.

THE BENEFIT AND HOW TO USE IT

Simply present your card and your prescription to the pharmacist. The prescription benefit allows for a 30-day supply with refills, as prescribed by your physician. The Plan will cover all Federal Legend drugs, State Restricted drugs, Compound medications, Insulin on prescription, Needles and Syringes on prescription, Injectables, Allergy Serums, Federal Legend Vitamins, Prescription Prenatal Vitamins, Imitrex and Imitrex Auto Injector, Diabetic Supplies, Diabetic Tablets and Bee Sting Kits.

EXCLUSIONS

Fertility drugs, Smoking cessation drugs, Genetically Engineered drugs, Immune Altering drugs and Federal Legend Oral Contraceptives will be excluded. (Some exceptions apply. Please contact the Fund Office for further information).

Pharmacy Exclusions:. These pharmacy providers, by their policies and actions, have demonstrated hostility towards organized labor and the millions of working people represented by organized labor.

- ⦸ **Wal-Mart**
- ⦸ **Walgreens**
- ⦸ **Marc's**

The ESI card is not valid at these pharmacy chains nor will there be any reimbursement eligibility for non-emergency prescriptions.

In the event that a network pharmacy is not available for medical emergencies a claim may be submitted for consideration of reimbursement minus the applicable co-payment directly to the Fund office.

PRESCRIPTION DRUG COVERAGE AND MEDICARE

The Fund has determined that the prescription drug coverage offered by this Plan is expected to pay out as much as the standard Medicare prescription drug coverage will pay.* People with Medicare can enroll in a Medicare prescription drug plan each year during open enrollment from October 15th through December 7th**. If the Employee enrolls in a Medicare prescription drug plan, he can keep his current prescription drug coverage with the Fund which will remain primary to Medicare. For additional information regarding your prescription drug coverage and Medicare please contact the Fund office.

**On average for all Plan Participants*
*** Dates subject to change each year.*

SECTION 12
EMPLOYEE ASSISTANCE PROGRAM

From time to time virtually everyone encounters problems and conflicts, which can feel overwhelming. The Plan provides an Employee Assistance Program (EAP) through its third party vendor that provides confidential consultations to help you successfully manage life's challenges. EAP counselors will listen to your concerns, help identify the source of your problems, and work with you to bring about practical solutions as quickly as possible. Effective January 1, 2014, the EAP will be administered through ComPsych. For additional details, contact the Fund Office.

The vendor and its network of skilled EAP counselors offer you a choice of either face-to-face or convenient scheduled telephone consultations. Each counselor is trained, credentialed, and experienced in helping you or your eligible dependent. This program can help with issues such as:

- Marital Relationships
- Alcohol Problems
- Stress Management
- Family/Parenting Relationships
- Drug Problems
- Depression and Anxiety
- Grief and Loss
- Financial Pressures
- Difficult Emotional Issues
- Spousal/Child/Parent Abuse
- Work Relationships
- Smoking Cessation

SECTION 13
GENERAL EXCLUSIONS

__The Plan does not provide benefits for services, supplies or charges:__

1. Which are not prescribed by or performed by or under the direction of a physician or professional provider.
2. Which are not performed within the scope of the provider's license.
3. Received from other than a provider.
4. Which are experimental/investigative drugs, devices, medical treatments or procedures.
5. Which are not medically necessary, as determined by the Plan.
6. To the extent governmental units or their agencies provide benefits.
7. For an injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war, work related incident, or during the commission of a felony by the covered Participant.
8. For which you have no legal obligation to pay in the absence of this or like coverage.
9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
10. Received from a member of your immediate family.
11. Incurred before your effective date.
12. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
13. Which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness.
14. For surgery and other services only to improve appearance but not to restore a bodily function or correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes.
15. For inpatient admissions, the primary purpose of which is:
    - Diagnostic Services;
    - Custodial Care;
    - Rest care;
    - Environmental change; or
    - Treatment by physical means.

    When these services could have been performed on an outpatient basis and it was not medically necessary that you be an Inpatient to receive them.

16. Primarily for educational, vocational or training purposes.

17. For organ transplant services:
    - Which are not furnished through a course of treatment which has been approved by Medical Mutual.
    - Which are not provided during a Transplant Benefit Period.
    - For other than a legally obtained human organ or for a human organ acquired outside the United States or Canada.
    - For travel time and the travel-related expenses of a provider.

18. For arch supports and other foot care or foot support devices only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bond surgery), calluses, toenails and the like.

19. For artificial insemination or in vitro fertilization.

20. For reverse sterilization.

21. For the treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.

22. For or related to the treatment of temporal mandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporal mandibular joint dysfunction not caused by documented organic disease or physical trauma.

23. For detecting and correcting by manual or mechanical means (including incidental X-ray) structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column unless a specific diagnosis is provided.

24. For expenses of care for conditions that state or local law require be treated in a public facility.

25. For topical anesthetics or stand-by anesthesia.

26. For penile implants or any treatment leading to or in connection with penile implants for a Condition not caused by a physiological disorder

27. For amounts you must pay as a deductible or copayment.

28. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.

29. The portion of any charge for a service or supply in excess of the reasonable and customary charge.

30. Blood or blood plasma that is replaced by or for the patient.

31. Incurred after you stop being a Covered Person except as otherwise specified in Plan.

32. For the following:

- physical examinations or services required by an insurance company to obtain Insurance;
- physical examinations or services required by a governmental agency such as the FAA and DOT;
- physical examinations or services required by an employer in order to begin or to continue working;
- premarital examinations;
- screening examinations, except as specified.

33. For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.

34. For weight loss Surgery and any repairs, revisions or modifications of such Surgery, including weight loss device removal, unless determined by Medical Mutual to be a Covered Service in accordance with Medical Mutual's corporate medical policy.

35. For water aerobics.

36. For residential care rendered by a Residential Treatment Facility.

37. For marital counseling.

38. For the medical treatment of sexual problems not caused by a biological Condition.

39. For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.

40. For weight loss drugs.

41. For male contraceptives and over-the-counter birth control without prescriptions.

42. For maternity services for dependent children.

43. Incurred as a result of any Covered Person acting as or contracting to be, a surrogate parent.

44. For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic except when due to trauma, accident or as deemed Medically Necessary by Medical Mutual.

45. For personal hygiene and convenience items.

46. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery.

47. For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis).

48. For massotherapy or massage therapy.

49. For hypnosis and acupuncture.

50. For After Hours Care.

51. For telephone consultations, online consultations, missed appointments, completion of claim forms or copies of medical records.

52. For fraudulent or misrepresented claims.

53. For blood which is available without charge.

54. For Outpatient blood storage services.

55. For Prescription Drugs, except as specified.

56. For hearing aids.

57. For over the counter drugs, vitamins or herbal remedies.

58. For specialized camps.

59. For Routine Services, except as specified.

60. For a particular health service in the event that a Non-PPO Network Provider waives Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) no benefits are provided for the health service for which the Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) are waived.

61. For non-covered services or services specifically excluded in the text of this Benefit Book.

SECTION 14
COORDINATION OF BENEFITS

If you have coverage under more than one plan, this Plan will coordinate with your other plan.

Coordination of Benefits provides complete payment of your allowable expenses while preventing duplicate payments for the same service. The objective is to make sure the combined payments of all healthcare plans are no more than your actual bills.

Coordination of Benefits does not apply to your Death Benefit, nor does it apply when you or your Dependents have individual health policies.

Coordination of Benefits does take place when you and your Dependents are covered by this Plan and another plan that provides group health and welfare benefits. This is especially common when both you and your spouse work, with each of you covered as a dependent under the other person's group health insurance plan.

Primary responsibility, when there is coverage under more than one group plan, is decided by these rules, in the following order:

1. If you have coverage under another group plan that does not coordinate benefits, that group plan will always be primary.

2. Participant and Dependents
   The plan which covers you as a participant has primary responsibility before the plan covering you as a dependent.

3. Children (Parents Divorced or Separated)
   If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

   If the court decree gives joint custody and does not mention health care, we follow the "birthday rule." The healthcare plan of the parent with the first birthday in a calendar year is always primary for the children. For example: If your birthday is in January and your spouse's birthday is in March, your health care plan will be primary for all of your children.

4. Children and the Birthday Rule
   When your children's healthcare expenses are involved, we follow the "birthday rule."

5. Adult Children
   If an adult child is covered under this Plan as your dependent, but is also married and covered under his or her spouse's group plan, then the adult child's spouse's plan will be primary to this Plan.

When this Plan has primary responsibility, you or your covered Dependents will receive coverage without regard to any coverage that you or your Dependents have under another plan.

When the other plan has primary responsibility, it must first pay its full benefit. This Plan will then pay any remaining covered expenses up to the amount that it would have paid if it had primary responsibility, unless payment is excluded by a provision of the Plan.

Spouse
If the spouse of a Plan participant is employed by an employer that provides, or will provide upon proper application, healthcare benefits for either single or family coverage, said spouse must apply for and accept such coverage if: The monthly premium rate payable by such spouse for health care coverage (single or family) is no more than the non-Medicare, monthly premium cost then in effect under the applicable provisions of the Plan. Failure to obtain such health coverage shall result in this Fund providing only secondary coverage.

In the event your spouse's employer includes in its program a provision that health insurance is not provided to your spouse because other health insurance may be available to them through this Fund, the Board of Trustees will deny any benefits to your spouse, and he or she will not be considered an eligible dependent for purposes of the Plan.

NOTE: Please be sure to include Coordination of Benefit information when completing any forms for services received or initially, when you complete your enrollment forms. This will include the name of your legal spouse's employer and the identification of any other group insurance plan. Incomplete information will only delay the processing of your claim.

Each year, all Plan participants will be asked to update this information by completing a questionnaire supplied by the Fund.

COORDINATION WITH MEDICARE

The Plan will pay its benefits before Medicare only for:

- An active Participant who is age 65 or older;
- An active Participant's dependent spouse who is age 65 or older;
- The first thirty (30) months of treatment in the case of any covered person entitled to Medicare solely on the basis of end-stage renal disease;
- Any person covered under the benefit program for active Participants who is less than 65 years of age and who is receiving Medicare benefits because of disability.

When the rules above do not apply, the Plan will pay its benefits only after Medicare has paid its benefits.

IMPORTANT: The Plan does not provide any coverage to Medicare-eligible individuals who do not enroll in Medicare Part A and Part B.

If you receive treatment at a hospital operated by the Veterans Administration for an illness or injury which is not related to military service, the medical benefits paid by the Plan will be the amount you would have received had the service been provided in a non-governmental facility, with Medicare as the primary payor.

FOR PARTICIPANTS OR DEPENDENTS WHO ARE ELIGIBLE FOR MEDICARE

The following is information about your current prescription drug coverage with the Fund and prescription drug coverage available through Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage will be available to everyone with Medicare.
2. The Fund has determined that the prescription drug coverage offered by the Plan is expected to pay out as much as the standard Medicare prescription drug coverage will pay.*
3. Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

The Fund has determined that your prescription drug coverage with the Plan is expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

Prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. You will have the opportunity to enroll in a Medicare prescription drug plan once per year, during open enrollment.

** On average for all plan participants.*

If you decide to enroll in a Medicare prescription drug plan, you can keep your current prescription drug coverage with the Fund. If you choose not to enroll in a Medicare prescription drug plan at this time, you may enroll in the future during Medicare's annual enrollment period. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage:
Contact the Fund Office at (330 744-3148) for further information about your current prescription coverage

For more information about your options under Medicare prescription drug coverage:

- Visit www.medicare.gov for personalized help,
- Calling your State Health Insurance Assistance Program (see you copy of the "Medicare & You" handbook for its telephone number)
- Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048
- For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: You may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

SECTION 15
SUBROGATION AND REIMBURSEMENT

The Fund's right of subrogation and recovery arises and will be exercised when any benefits, including short-term disability, hospital, surgical and/or medical benefits, are paid to or on behalf of a participant or Dependent (hereinafter referred to as the "Covered Person") due to a loss, injury or illness for which another person or entity is or may be legally responsible or which arises under any no-fault coverage. This would include but not be limited to a loss, injury or illness compensable under the workers' compensation system, and/or due to medical malpractice, negligence, tortious and/or criminal conduct of a third party, or any other situation. In consideration for the Fund's advancement of benefits in this context, the Covered Person agrees to the terms set forth herein.

The Fund shall be fully reimbursed when recovery occurs or is available from any source, including but not limited to the person or entity that is or may be responsible for such loss, injury or illness, the insurer of such person or entity, the Covered Person's insurer including coverage for medical payments, underinsured and/or uninsured motorists coverage, at fault or no-fault insurance, casualty or liability insurance the workers' compensation system, or any other source (each of the aforementioned hereinafter collectively referred to as "Responsible Person(s)"). Such recovery includes but is not limited to court judgments, administrative or agency orders, private settlements, any and all monies however characterized, or any other payments. No settlement shall be made or release given for claims arising out of the Covered Person's loss, injury or illness without prior written consent of the Fund. In consideration for the Fund's advancement of benefits in this context, the Responsible Person(s) agrees to the terms set forth herein.

In connection with the above paragraphs, the Fund shall be reimbursed in the full gross amount of any and all benefits, of whatever type, paid or otherwise provided by the Fund. The Fund shall receive full and complete reimbursement first, and prior to any other disbursements including disbursement to the Covered Person, payment of attorneys' fees and/or expenses. The Fund's right to full reimbursement shall not be subject to reduction for reasons including but not limited to the Covered Person's failure to recover the perceived full or actual value of his or her claim for whatever reason, attorneys' fees, expenses or other costs, and/or the Fund's failure to actively participate in the claim and/or recovery. Further, the Fund expressly rejects and otherwise prohibits application of the "make-whole" doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights. Additionally, the Fund expressly rejects, disclaims and otherwise prohibits application of the "common fund" doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights.

The Covered Person shall complete all paperwork deemed necessary by the Fund to protect its subrogation interests, including the signing of the Fund's subrogation and reimbursement agreement; failure to do so entitles the Fund to deny coverage for the subject loss, injury or illness. The Covered Person will do nothing to impair or negate the Fund's right of subrogation and will fully cooperate with the Fund. If the Covered Person performs any act or fails to act, fails to reimburse the Fund in the full amount of benefits of whatever nature that were paid by the Fund, or otherwise compromises the Fund's rights, the Fund may immediately seek recovery of all benefit amounts paid by any available means, including legal action. The Fund shall also have the right to offset any future benefit payments that would otherwise be payable to or on behalf of the Covered Person, to the extent of its lien. These offset benefits shall be permanently forfeited by the Covered Person and the Covered Person shall be legally responsible for any unpaid amounts.

In addition to the Plan's reimbursement rights, the Plan may also choose to exercise its direct subrogation rights. If the Plan pursues direct subrogation, the Covered Person assigns to the Fund any and all claims, demands and contractual rights the Covered Person has or may have against Responsible Person(s) arising from or related in any way to the Covered Person's loss, injury or illness, and agrees that the Fund is substituted in the place of the Covered Person against such Responsible Person(s) to the extent of the amount paid by the Fund as a result of such loss, injury or illness. This entitles the Fund to

make claim or file suit in the name of the Covered Person. The Covered Person agrees that the Fund shall hold a lien against any amounts the Covered Person receives, will receive or has available from any source as a result of the loss, injury or illness to the extent of benefits paid by the Fund. The Covered Person agrees that the Fund may at any time notify or otherwise communicate with the Responsible Person(s) and the Covered Person's attorney and release information relative to the loss, injury or illness. The Covered Person agrees to promptly make claims against the Responsible Person(s), and, if necessary, to commence and prosecute a lawsuit against such Responsible Person(s) with all due diligence. Any recipient of settlement proceeds or assets collected from judgments are subject to the imposition of a collective trust.

Constructive Trust

A Participant or his attorney who receives any recovery (whether by judgment, settlement, compromise or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision or otherwise make restitution to the Plan. A Participant or his attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

Recoupment

If the plan should provide any form of benefit under the Plan to you and/or your dependent(s) and, for whatever reason, such benefit was not required under the terms of the Plan or otherwise mistakenly paid, the Plan shall have the right to offset future benefits to the extent of the overpayment. This provision does not limit the Plan's right to recover such amount by any other lawful means.

Rescission of Benefits: In accordance with the Patient Protection and Affordable Care Act (the "Affordable Care Act"), the Fund will only "rescind," or cancel, or discontinue coverage retroactively in cases where a participant or the participant's eligible dependent (or a person seeking coverage on behalf of such individual) has performed an act, practice, or omission that constitutes fraud, or in cases where such an individual makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Fund. If the Fund seeks to rescind benefits on such grounds, it will provide the individual with thirty (30) calendar days advance written notice prior to rescission, along with information about appeal rights. Please note that a retroactive termination of coverage due to a participant's failure to timely pay premiums is not a rescission.

WORKERS COMPENSATION

Any benefits paid by the Plan which are also covered by Workers Compensation laws entitles the Fund to full reimbursement, as provided in the Subrogation section of this document. Furthermore, if an accident or sickness is related to your employment, and is compensable under state Workers Compensation laws or similar laws, any resulting expenses and/or benefits are excluded from payment by this Plan. *See,* General Exclusions section of this booklet. Your Summary of Benefits (including Prescription Drug Benefit) does not replace Workers Compensation Benefits.

Workers Compensation is a state fund to which your employer contributes and which pays for work-related injuries or illnesses. It is to your advantage to know what kind of protection Workers Compensation provides you.

State Workers Compensation laws vary from state to state. You should know about the law in your state. To find out, call your State Bureau of Workers Compensation (each state has one) or a local office. It is their job to see that your claim is handled quickly and efficiently.

The most important thing to remember is don't wait. Act immediately! Often there are time limits on how long you can take to file a claim. If you miss the time limit, you may not be able to file at all.

Here are some suggestions to help you get the benefits that belong to you:

1. Let your employer know when you are injured or think that you are ill because of conditions on the job.
2. See a physician right away, preferably one who has taken Workers Compensation cases and knows your industry.
3. Get in touch with your Fund Office. They can help you contact the right offices and people.
4. Contact your state Workers Compensation office or a local office to get your claim started.

   NOTE: If a claim is denied under this section, and you are appealing a ruling by the Compensation Commission, you may receive benefits under a Subrogation Agreement. If you believe that you qualify for such an Agreement, you may write the Fund and request one. Such requests are reviewed on an individual basis.

SECTION 16
CLAIMS AND APPEALS PROCEDURES

CLAIM FILING AND PAYMENT

A claim must be filed for you to receive benefits. If services have been supplied by contracting provider (hospital, physician, or other provider), the provider will submit the claim for you. You will have no claim forms to file and will not be balanced billed for the difference between the Negotiated Rate and billed charges.

If you choose to receive services from any hospital, physician, specialist, laboratory or other health care provider who has not contracted with Medical Mutual of Ohio, that provider may also submit a claim for you. However, some non-contracting providers will not and you may have to file your own claim. You can obtain a claim form from the provider or from the Fund Office.

File your claim as soon as possible. Fill out your part of the form by following the instructions and be sure the other portions of the form are completed accurately by the appropriate person, when necessary. Also check your social security number on the form to insure its accuracy. Mail the completed form to Medical Mutual, along with any items requested on the form. If additional information is needed, you will be contacted.

The claim will be reviewed to ensure that the service was medically necessary and that all other conditions for coverage were satisfied. Payments will be made directly to the provider, if the provider is contracting or participating with Medical Mutual. You cannot assign your right to payment to anyone else.

Hospitals, physicians and other providers are designated as contracting and non-contracting or network and non-network. The amount of benefits which you will receive for covered services may vary depending on the status of the provider. You will receive the maximum benefits by seeking covered services from a network provider. See the Summary of Benefits schedule.

HOW TO FILE A CLAIM UNDER THE MEDICAL MUTUAL MEDICAL PLAN

When you receive health care services:

- Show your identification card to the service provider
- Ask the provider to file a claim for you

In the case that you and your dependents use Providers who participate in the Medical Mutual Network, the provider will submit a claim for you directly to Medical Mutual for payment. Payments will then be made directly to the provider.

If you and your dependents use providers that do not participate in the Medical Mutual network it is your responsibility to submit the claim to Medical Mutual for payment. In some instances the provider will submit the claim to Medical Mutual.

If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the hospital, doctor or medical facility
- Obtain a claim form from the Fund's Administrative Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

- Participant's name and address
- Patient's name and address
- Date of Service
- Type of Service and diagnosis
- Itemized charges
- Provider's complete name, address and tax identification number

Submit original itemized bills and make copies of these bills for your own records. Once submitted, itemized bills cannot be returned. When submitting an itemized bill, all information must be on the provider's pre-printed letterhead or stationery. Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

Payment for these Non-Participating or Out of Network Providers will be made to you directly once you have met your deductibles, copayment and coinsurance obligations. It is your responsibility to provide this payment to your provider.

A claim is not filed until it is received by Medical Mutual. They will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, Medical Mutual may request additional information from you or the provider. You and/or your provider will have at least 45 days to submit the additional information.

When certain expenses are not eligible for payment under the Plan, you will be notified by Medical Mutual that the claim is denied in whole or in part with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

- The specific reasons for the adverse benefit determination;

- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Medical Mutual Appeals Procedure set forth below.

URGENT CARE CLAIMS

An **Urgent Care Claim** is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of ***urgent*** can be made by (a) an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of medicine or (b) any Physician with a knowledge of the claimant's medical condition who can determine that a claim involves urgent care.

If you file an Urgent Care Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after Medical Mutual's receipt of the claim.

If you do not follow Medical Mutual's procedures or we do not receive all of the information necessary to make a benefit determination, Medical Mutual will notify you within 24 hours of receipt of the Urgent Care Claim and explain the applicable procedural deficiencies, or the specific deficiencies related to information necessary to make a benefit determination. You will have 48 hours to correct the procedural deficiencies and/or provide the requested information. Once Medical Mutual receives the requested information, we will notify you of the benefit determination as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the information.

Medical Mutual may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

CONCURRENT CARE CLAIMS

A Concurrent Care Claim is any claim for ongoing treatment to be provided over a period of time or for a number of treatments, subject to Medical Mutual's approval. The decision is adverse if Medical Mutual decides to reduce or terminate benefits for the ongoing treatment (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

A request for an extension to an ongoing course of treatment must be filed in accordance with Medical Mutual's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Medical Mutual will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours after its receipt of the claim.

If Medical Mutual reduces or terminates a course of treatment before the end of the course previously approved, the reduction or termination is considered an adverse benefit determination. Medical Mutual will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

PRE-SERVICE CLAIMS

A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by Medical Mutual as a condition for payment of a benefit (either in whole or in part).

If you file a Pre-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 15 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

POST-SERVICE CLAIMS

A Post-Service Claim is any claim that is not a Pre-Service Claim or an Urgent Care Claim.

If you file a Post-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 30 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 30 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

BENEFIT DETERMINATION NOTICES

You will receive notice of a benefit determination orally, as allowed, or in writing. All notices of a denial of benefit will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- sufficient information to identify the claim involved, including the date of services, the health care provider, and the claim amount, if applicable;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- a statement of your right to bring a civil action under federal law following the denial of a claim after review on appeal, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA);

- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request and;
- if the claim was denied based on Medical Necessity or Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request.

FILING A COMPLAINT

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Employee should have the following information available:

- name of patient
- identification number
- claim number(s) (if applicable)
- date(s) of service

If your complaint is regarding a claim, a Medical Mutual Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Group Contract, the Customer Service representative will telephone the Employee with the response. If attempts to telephone the Employee are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Employee will receive a check, Explanation of Benefits or letter explaining the revised decision.

Quality of Care issues are addressed by our Quality Improvement Department or committee.

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

HOW TO FILE A CLAIM FOR DENTAL AND VISION BENEFITS

When you receive dental or vision services, show the provider your Identification Card. The provider may submit a claim form on your behalf to the Teamster's Fund Office or may require you to pay for the services in full and submit the claim for reimbursement yourself. However, if you have exceeded the annual maximum on your dental benefits, you will be responsible to pay the remainder of the bill to the provider directly once the Fund issues payment.

If you must submit a claim for Dental and Vision serves you should:

- Obtain an itemized bill from the provider
- Obtain a claim form from the Fund Administrator Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

- Participant's name and address
- Patient's name and address

- Date of Service
- Type of Service and diagnosis
- Itemized charges
- Provider's complete name, address and tax identification number

Please note: If you have already made payment for the services you received, you must also submit proof of payment with your claim form. Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

You must submit originals of all itemized bills. You should make copies of the itemized bills for your own records. Once your claim is received, itemized bills cannot be returned.

In the event you do not provide proof of your payment to the provider, the payment from the Fund will be made to the provider directly on your behalf.

A claim is not filed until it is received by the Fund Office. We will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund Office may request additional information from you or your provider. You and/or your provider will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Plan, you will be notified by the Fund Office that the claim is denied in whole or part with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Fund's Appeals Procedure set forth below.

HOW TO FILE A CLAIM FOR PRESCRIPTION BENEFITS UNDER THE E.S.I. PROGRAM

You will receive a personalized Express Scripts, Inc. (ESI) Prescription Benefits Identification Card with eligible family status listed on the card. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating ESI pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally have you sign a form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase is not a claim for benefits. If you do not receive your prescription at the ESI retail pharmacy due to denial of coverage, you need to contact the Fund Office to make a claim for benefit coverage.

If you elect to have your prescription filled by a pharmacy other than a participating ESI pharmacy, do not use your ESI Prescription Benefits Identification Card. Follow the Claim Reimbursement Procedure described below to obtain reimbursement of prescription expenses.

You can obtain a ESI Direct Reimbursement form from the Fund Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to the address on the form. Reimbursement will be made directly to you by ESI on the same basis as benefits would have been paid to a participating ESI pharmacy.

If you are not eligible for benefits at the time you contact the ESI pharmacy or in the event that the prescription is not a covered drug under the Plan, you must contact the Fund Office for additional information (and to make a claim for coverage of the prescription benefits). The Fund Office will review the claim and if the claim is denied in whole or in part, will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Fund's Appeals Procedure set forth below.

HOW TO FILE A CLAIM FOR DEATH, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Claims should be submitted to the Fund Office as soon as possible; do not delay in filing any claims. Claims for Death, Accidental Death and Dismemberment benefits will be provided through the Fund Office. Your beneficiary must submit the completed claim form. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. This will generally include a death certificate and documentation to establish the death or dismemberment is the result of an accident.

Generally, the Fund Office will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that the Fund Office needs additional time to review the claim for benefits or needs additional information, your beneficiary will be provided with the information on the status prior to the expiration of the initial 90 day period.

When the claim for death benefits falls within the Funds exclusions, your beneficiary will be notified by the Fund Office that the claim is denied in whole or part with an explanation of the reasons for the denial.

He/she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The sections of the Plan and/or Summary Plan Description upon which the adverse benefit determination was based;
- A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Fund's Appeals Procedure set forth below.

HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS

Claims should be submitted to the Fund Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Teamster's Fund Office to be completed by you, your employer and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund Office notifies you of the delay.

If the Fund Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund Office receives the information from you, you will be notified of the decision on the claims within 30 days.

In the event that your claim is denied in whole or in part, the Fund Office will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of the Fund's Appeals Procedure set forth below.

PROOFS OF CLAIM

Written proofs of claim for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. **All claims must be submitted by you or the Provider no later than one year from the date on which the services were incurred. Any claims submitted after one year shall result in denial of your claim**. A health service shall be considered as Incurred on the date services or supplies are rendered or received.

PHYSICAL EXAMINATION AND AUTOPSY

The Fund reserves the right to have the eligible person examined, at its own expense, as often as reasonably necessary while a claim is pending. The Fund further reserves the right to have an autopsy performed unless the same is forbidden by law.

LEGAL ACTION

No attempt to recover more benefits from the Plan through legal action may be instituted until the eligible person completes the appeals procedure.

APPEAL PROCESS

REVIEW PROCEDURE FOR MEDICAL CLAIMS PROVIDED THROUGH MEDICAL MUTUAL

FILING AN APPEAL

- Please note: The processes described here are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the claims and appeals processes for this plan are subject to change. The rules and/or procedures set forth in the most current claims and appeals regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth herein.

If you are not satisfied with any of the following:

- a benefit determination;
- a Medical Necessity determination;
- a determination of your eligibility to participate in the plan or health insurance coverage; or
- a decision to rescind your coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums)

then you may file an appeal.

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card for more information about how to file an appeal. You may also write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

Medical Mutual
Member Appeals Unit
MZ: 01-4B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
FAX: (216) 687-7990

The request for review must come directly from the patient unless he/she is a minor or has appointed an authorized representative. You can choose another person to represent you during the appeal process, as long as Medical Mutual has a signed and dated statement from you authorizing the person to act on your behalf.

MANDATORY INTERNAL APPEAL

The Plan offers you a mandatory internal appeal. You must complete this mandatory internal appeal before any additional action is taken, except under specific circumstances as described in the following sections.

Mandatory internal appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by submitting an electronic form or in writing as described in the Filing an Appeal section above.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this plan. The internal appeal process is a review of your appeal by an appeals specialist, a Physician consultant and/or other licensed health care professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, Medical Mutual will provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

If, during the appeal, Medical Mutual considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of denial is issued. You will have an opportunity to respond before our time frame for issuing a notice of denial expires. Additionally, if Medical Mutual decides to issue a final denial based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires.

You will receive continued coverage pending the outcome of the appeals process. This means that Medical Mutual may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

URGENT CARE APPEAL

You, your authorized representative or your Provider may request an appeal for urgent care. The appeal does not need to be submitted in writing. You, your authorized representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment (1) could seriously jeopardize the life or health of a patient, or could affect the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed with the care or treatment that is the subject of the claim. The appeal must be decided within 72 hours of the request. The expedited review process does not apply to prescheduled treatments, therapies, surgeries or other procedures that do not require immediate action. When you request an internal appeal for an urgent care claim, at the same time you may also file a request for an expedited external review as described below.

Pre-Service Claim Appeal

- You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post Service Claim Appeal

- You or your authorized representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

All appeal denial notices will be culturally and linguistically appropriate and will include the following:

- the specific reason (s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- sufficient information to identify the claim involved, including the date of services, the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relative to your claim for benefits;
- notice of availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- a description of applicable appeal procedures; and
- a statement of your right to bring civil action under federal law following the denial of a claim upon review, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

If your claim is denied at the internal mandatory appeal level, then depending on the type of plan you have and the type of claim, there are two different voluntary review options available. You will be eligible for EITHER the External Review Process OR the Voluntary Internal Review Process. These two processes, and their eligibility requirements are described below.

EXTERNAL REVIEW PROCESS

Medical Mutual has established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within four months from your receipt of the notice of denial from the internal mandatory appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process unless under applicable law you are not required to exhaust the internal appeal process;
3. You are or were covered under the plan at the time the service was requested, or, in the case of retrospective review, were covered under the plan when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IRO). You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

Medical Mutual is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical condition and the external review.

EXTERNAL REVIEW FOR NON-URGENT CARE CLAIM APPEALS

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed above.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you ten business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. The written decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you. If the IRO reverses the adverse benefit determination, the Plan will provide coverage or payment for the claim.

EXPEDITED EXTERNAL REVIEW FOR URGENT CARE CLAIM APPEALS

A request for an external review for Urgent or Expedited claims may be requested orally or electronically in writing and should be addressed to Medical Mutual's Member Appeals Unit. You may request an external review for Urgent or Expedited claims at the same time you request an expedited internal appeal of your claim.

An expedited review may be requested if your Condition, without immediate medical attention, could result in serious jeopardy to your life or health or your ability to regain maximum function; or you have received a final internal appeal denial concerning an admission, availability of care, continued stay or health care item or service for which you received emergency services, but you have not been discharged from a facility.

If your request for an external review is complete and you are eligible for external review, and IRO will conduct the review. The IRO will issue a decision within seventy-two hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or you. If the IRO reverses the adverse benefit determination, the Plan will provide coverage or payment for the claim.

VOLUNTARY INTERNAL REVIEW PROCESS

If your internal mandatory appeal is denied, and your claim does not qualify for an external review, you have the option of a voluntary internal review by Medical Mutual. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental x-rays, photographs and other information that were not submitted for the internal mandatory appeal.

The voluntary internal review may be requested at the conclusion of the internal mandatory appeal. The request for the voluntary internal review must be received by Medical Mutual within 60 days from the receipt of the internal mandatory appeal decision. Medical Mutual will complete its review of the voluntary internal review within 30 days from receipt of the request.

The voluntary internal review provides a full and fair review of the claim. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the

claim, without regard to whether such information was submitted or considered in the internal mandatory appeal.

REVIEW PROCEDURE FOR DENTAL, VISION, PRESCRIPTION, DEATH, DISMEMBERMENT AND WEEKLY DISABILITY BENEFITS

You or your authorized representative may appeal the decision by the Fund Office to deny any claim for dental, vision, death, accidental death, accidental dismemberment or weekly disability benefits in whole or part. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure. If you are not handling your own claim, then an "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

You may file a written notice of appeal to the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, telephone number and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice. The Appeal should be addressed as follows:

Board of Trustees
Teamsters Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown Ohio 44502

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Board of Trustees shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Board of Trustees will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", at its next regularly scheduled quarterly meeting. In the event that your appeal is received less than thirty (30) days prior to the scheduled meeting date, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You will be notified of the decision of the Board of Trustees as soon as possible after the meeting, but in no case later than five (5) days after the decision is made.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file suit under ERISA Section 502(a).

The decision of the Board of Trustees is final and binding.

VOLUNTARY APPEAL TO THE BOARD OF TRUSTEES

Once you have filed your appeal through Medical Mutual and the IRO contracted by Medical Mutual as detailed above, and you have been denied at both levels of review, you have the right to file a lawsuit in federal court. However, prior to initiating federal court action you can also file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within 60 days of the mailing of the Notice of Final Decision on your appeal.

The Appeal should be addressed as follows:

Board of Trustees
Teamsters Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown Ohio 44502

The Board of Trustees will review the appeal at their next scheduled quarterly meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

1. The Plan will not assert a failure to exhaust administrative remedies;
2. The Plan agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;
3. The Plan requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
4. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:
   - A statement that using this procedure will have no effect on your right to receive other benefits under this Plan.
   - A statement that you have the right to have a personal representative with regard to your claim.
   - A notice of any circumstances which may impair the impartiality of the Board of Trustees.
5. The Plan will not impose any fees or costs on you as part of this voluntary appeal process.

In the event that the denial is upheld, you will receive a written Notice which includes the following:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affect your claim, if applicable; and
- A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Board of Trustees is final and binding.

DECISION ON APPEAL TO BE FINAL

The decision by Medical Mutual, IRO, Express Scripts, Inc., or the Board of Trustees, as applicable, on appeals shall be final, binding and conclusive and will be afforded the maximum deference permitted by law unless found by a court of competent jurisdiction to be arbitrary and capricious. **The mandatory levels of appeal must be exhausted before any legal action is brought. Any legal action for benefits must be commenced within one (1) calendar year after these claims' review procedures have been exhausted.**

SECTION 17
MILITARY SERVICE PROVISION

The Trustees wish to provide notice to you that if you are called up for active duty in the armed services, the Fund will provide you with the ability to retain coverage during the time you are in qualified military service. If you are in qualified military service for less than 31 days, the cost of continuation coverage will be the responsibility of the Fund, provided you meet the conditions for re-employment. If you are in qualified military service for more than 31 days, the cost of providing continuation of coverage will be your responsibility.

If you are in qualified military service for more than 31 days and elect to continue coverage under this Fund for you and your dependents, if applicable, you will be entitled to continue coverage by making self-payments for a maximum period of eighteen (18) months.

If you served between 31 and 81 days in qualified military service, your coverage will be reinstated on your re-employment with any Employer under this Fund if you apply for re-employment within 14 days after your honorable discharge. If your service exceeded 181 days, you must apply for re-employment within 90 days after your honorable discharge.

You need to contact the Fund Office to discuss your options to continue coverage for you and your dependents. In most instances, when you are called to active duty, coverage is provided to you through Tri-Care, which offers several plans to persons on active duty and, under certain conditions, his/her dependents.

It is extremely important, if you wish to have a continuation of benefits that immediately upon learning of your armed service related absence for any period, you discuss your options with the Fund Office.

SECTION 18
CONTINUATION OF COVERAGE – COBRA

Federal law requires the Fund to offer you and your eligible dependent(s) the opportunity for a temporary extension of health coverage at group rates, when coverage under the Fund would otherwise end. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you may continue health care coverage identical to the benefits the Plan provides to you at the time your coverage is terminated. You and your eligible dependent(s) will be required to pay the full cost of the coverage in order to continue it.

Continued coverage is not available to anyone who was not covered under the Plan before coverage ended. However, you may add newly acquired eligible dependents while covered under COBRA by notifying the Fund Office within 30 days after acquiring the new eligible dependent and paying the required premium.

If you do not choose continuation of coverage, your group health insurance coverage will end.

The following information will summarize your rights and obligations under the continuation of coverage provisions of COBRA. *You and your eligible dependents covered under the Fund* should take the time to read this information carefully.

CONTINUATION OF COVERAGE

Coverage May Continue for:	If:	Maximum Duration of Coverage
You and your eligible dependents	Your employment ends for any reason (except gross misconduct), including layoff, total disability, or retirement	18 months*
You and your eligible dependents	Your hours of employment are reduced	18 months*
You and your eligible dependents	You become absent from employment by reason of service in the military	24 months†
Your eligible dependents	You die	36 months
Your eligible dependents	You become eligible for Medicare	36 months
Your eligible dependents	You are divorced or legally separated from your lawful spouse	36 months
Your eligible dependent children	Your eligible dependent children ceased to be qualified as eligible dependents (for example, they reach age 26 and are no longer eligible under the Fund Plan)	36 months

*If you or one of your eligible dependents is disabled, COBRA coverage may continue for that person only for up to 29 months. Timely proof of eligibility for Social Security Disability Benefits is required for continuation of the additional 11 months of coverage.

†The right to election exists even if the eligible employee will also be covered under a military health plan.

When one of these situations occurs, the Fund Office, upon notification, will give you or your eligible dependents all the details regarding continuation coverage, including the cost. It is your responsibility, however, to inform the Fund Office of a divorce, legal separation or of a child losing eligible status under the Plan.

Under COBRA, the participant or a family member has the responsibility to inform the Fund Office within 60 days of a "qualifying event", such as divorce, legal separation, or a child losing dependent status. While it is the responsibility of the participant's employer to notify the Fund Office within 30 days of the employee's death, termination of employment, disability, layoff, reduction of hours, retirement or entitlement to Medicare, the participant or other family member should notify the Fund Office if any of these qualifying events occur in order to assure timely notification of eligibility for, and processing of, an election of continuation of coverage.

When the Fund Office is notified in writing that one of these events has occurred, you will be notified within 14 days after loss of coverage that you have the right to choose continuation of coverage. Under COBRA, you have at least 60 days from the later of the date your coverage terminated, or will terminate under the Plan, or the date of the notice advising you of your right to continuation of coverage, to inform the Fund Office that you want continuation of coverage.

If you do not choose continuation of coverage, your group health insurance coverage will end.

If you choose continuation of coverage, this Fund is required to give you group health coverage which, at the time coverage is being provided, is identical to the coverage provided under the Fund to similarly situated covered participants and their families in the same benefit plan. However, the Death Benefit, accidental death and dismemberment coverage and weekly income and sickness benefits will not be available under COBRA. In addition, under COBRA, you and/or your dependents will be allowed to choose continuation of either health coverage plus prescription drug or health coverage plus prescription drug, dental and vision benefits.

You and/or your dependents must pay the entire cost of continued group health coverage at group rates. The cost will not exceed 102% of the cost for providing health benefits to individuals in the same benefits selection situation as yourself. Specific cost information will be provided to you when you become eligible for continuation of coverage.

Regardless of which continuation period applies, COBRA provides that an individual's continuation of coverage may be cut short for reasons including:

1. This Fund no longer provides group health coverage.

2. The self-payment for continuation of coverage is not timely paid (within 30 days of the due date);

3. You or an eligible dependent become eligible under another employer-sponsored group health plan as an employee, dependent or spouse and the other plan does not contain any exclusion or limitation with respect to your or your dependent's pre-existing condition; or

4. You or an eligible dependent become entitled to Medicare.

You do not have to show that you are insurable to choose continuation of coverage.

SECTION 19
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT

If you were eligible to enroll under this Plan and declined coverage because you were covered under a group health plan, Medicaid, or other health insurance coverage, and lose the other coverage, you and your Dependent(s) will be permitted to enroll in this Plan during a special enrollment period. However, you must notify the Fund of your request for special enrollment within thirty (30) days after the other coverage ends. The Fund may require you to provide it with written documentation of the termination of the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your Dependent(s) in this Plan. However, you must provide the Fund with notice of your intent to enroll yourself and your Dependent(s) in this Plan within thirty (30) days of the event (having or becoming a new dependent). Coverage under these special enrollment provisions will be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received

SECTION 20
FAMILY AND MEDICAL LEAVE ACT OF 1993

Generally, the Family and Medical Leave Act (FMLA) requires your employer to provide you with up to twelve (12) weeks of unpaid leave during any twelve (12)-month period for specified family and medical reasons, if you are eligible. During this period, your employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing employer for at least twelve (12) months and for at least 1,250 hours during the twelve (12) month period before the leave begins. Generally, your employer is obligated to provide Family and Medical leave only if your employer employs fifty (50) or more employees each working day during each of twenty (20) or more work weeks during the current or preceding calendar year.

During the FMLA leave, your employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility.

A covered employer must grant an eligible participant up to a total of twelve (12) work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child or parent) with a serious health condition; or
- To take medical leave when the participant is unable to work because of a serious health condition.
- Eligible employees are entitled to up to twelve (12) weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
- An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness of injury sustained in the line of duty on active duty is entitled to leave up to twenty-six (26) weeks in a single twelve (12) month period to care for the service member. The military care giver leave is available during "a single twelve (12) month period" during which an eligible employee is entitled to a combined total of twenty-six (26) weeks of all types of FMLA leave.

Arrangements will need to be made for participants to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, a participant must be restored to his or her original job or to an equivalent job. In addition, a participant's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave.

Please contact the Fund office if you have any questions regarding your options under the FMLA.

REPAYMENT OF CONTRIBUTIONS TO EMPLOYER

If you take a leave under the **FMLA** and you fail to return to your Employer for any reason after such absence, under the Act your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your Employer, you should return work at the end of your leave of absence under the **FMLA**.

SECTION 21
WOMEN'S HEALTH AND CANCER RIGHTS ACT of 1998

Did you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Call your Plan Administrator at (330) 744-3148 for more information.

SECTION 22
NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

To the extent the applicable medical plan provides benefits for hospital lengths of stay in connection with childbirth, the plan will cover the minimum length of stay required for deliveries (i.e. a 48 hour hospital stay after a vaginal delivery or a 96 hour stay following a delivery by Caesarian section.) The mother's or newborn's attending physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by law. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing length of stay not in excess of 48 hours (or 96 hours). Such coverage shall be subject to any applicable deductible or coinsurance amounts as long as any cost-sharing provisions are consistent throughout the 48-hour or 96-hour (depending on the type of delivery) hospital length of stay period.

SECTION 23
MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

To the extent the applicable medical plan provides mental health and substance abuse benefits, it will not place financial requirements, such as co-pays and deductibles, and treatment limitations, such as visit limits, on mental health or substance use disorder benefits that are more restrictive than the predominant requirements or limitations applied to substantially all medical and/or surgical benefits. Such coverage shall be subject to any applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days and/or outpatient visits.

SECTION 24
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Neither the Plan nor any of the providers of benefit programs covered under HIPAA discriminate against any participant or Dependent on the basis of health related status which refers to medical condition, claims experience, receipt of health care, genetic information or disability. By discriminate the Plan means exclusion from coverage, eligibility rules, or higher premiums but does not mean setting limitation on amount level, or nature of benefits or coverage nor limitation on amount of premium that may be charged nor preexisting condition exclusions in conformity with HIPAA. The Plan and the carriers it retains to provide benefits coverage either do not have preexisting condition exclusions or if such exclusions exist they comply with the terms of HIPAA.

NEW FEDERAL REGULATIONS REQUIRE YOUR HEALTH PLAN TO FOLLOW NEW PROCEDURES TO PROTECT YOUR PRIVACY – SPECIFICALLY, THE PRIVACY OF YOUR HEALTH INFORMATION WITHIN THE CONTROL OF THE PLAN.

When you read the notice that the Plan is required to send to you under the new rules, please pay close attention to the following points:

- The rules allow the Plan to use and disclose your health information:
  - To pay claims; and
  - To administer the Plan.
  - Unless you object, the rules allow the Plan to communicate orally, electronically and by other means about the status of your claims and your eligibility for benefits with your spouse if you are married.

For example: The Fund Office may discuss: ➢ *Your claims* electronically, over the telephone or in person *with your spouse.* ➢ *Your spouse's claims* electronically, over the telephone or in person *with you.* As parents or guardians, you and your spouse will generally have continuing access to information regarding your minor children. The Fund will assume the person contacting them is involved with an individual's care if the person can identify the provider name and date of service.

If you do not wish to have the Fund Office discuss your protected health information with your spouse, you must complete the form on the next page and send it to the Fund Office. The form will take effect when the Fund Office receives it.

Privacy Request

To: Privacy Official
Teamsters Union Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown, OH 44502

The Fund Office does not have my permission to discuss my protected health information, including eligibility and claims status, with the person checked below unless I specifically authorized such a discussion in writing:

☐ My Spouse

Name: ____________________________ Social Security Number: __________________

Signature: ____ Date: ____________________

Privacy Notice

Section 1: Purpose of This Notice and Effective Date

This Notice Describes:	
1.	**How medical information about you may be used and disclosed; and**
2.	**How you may obtain access to this information.**
Please review this information carefully.	

Effective date. The effective date of this updated Notice is September 23, 2013.

This Notice is required by law. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),

2. Your rights to privacy with respect to your PHI,

3. The Plan's duties with respect to your PHI,

4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services, and

5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written or electronic form.

PHI refers to your health information held by the Plan.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your consent or authorization or the opportunity to object in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.

- ***To the Plan's Trustees.*** The Plan will disclose PHI to the Plan Sponsor for purposes related to treatment, payment and health care operations. The Plan Sponsor is the Board of Trustees. The Plan Sponsor has amended its Plan Documents to protect your PHI as required by Federal law. For example, the Plan may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.

- ***For treatment, payment or health care operations.*** The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:

> Treatment,

> Payment, or

> Health care operations.

The Plan does not need your consent or authorization to release your PHI when:

- you request it,
- a government agency requires it,
- Trustees are required to review it, or
- the Plan uses it for treatment, payment or health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. ***For example:*** The Plan discloses to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
Health Care Operations keep the Plan operating soundly.	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. ***For example:*** The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

> ***In general***, the Plan does not need your consent to release your PHI if required by law or for public health and safety purposes.

1. ***When required by law.***
2. ***Public health purposes.*** To an authorized public health official if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
4. ***Oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
7. ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:
   a. identifying or locating a suspect, fugitive, material witness or missing person, and
   b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. The Plan may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

13. ***Specialized Government Functions.*** When required, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization. Any revocation of any authorization must be in writing. The authorization form that you would use describes how to revoke an authorization. A revocation is not effective unless it is received by the Privacy Official.

Other Uses or Disclosures
The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan may disclose protected health information to the sponsor of the plan for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Plan is the Board of Trustees.

SECTION 3: YOUR INDIVIDUAL PRIVACY RIGHTS

You May Request Restrictions on PHI Uses and Disclosures and Receipt of PHI

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Official determines it to be unreasonable.

In addition, the Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI or to receive communications of PHI by alternative means or at alternative locations. Make such requests to:

Teamsters Union Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown, OH 44502

> ***Protected Health Information (PHI):*** includes all individually identifiable health information transmitted or maintained by the Plan, regardless of the form of the PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

> ***Designated Record Set:*** includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer:

Teamsters Union Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown, OH 44502

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Plan and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to make a written request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

> If you disagree with the record of your PHI, you may amend it.
>
> If the Plan denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.
>
> Forms are available for these purposes.

You should make your written request to amend PHI to the following officer:

Teamsters Union Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown, OH 44502

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI. The Plan does not have to provide you with an accounting of disclosures related to treatment, payment or health care operations or disclosures made to you or authorized by you in writing.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain an additional paper copy of this Notice, contact the following officer:

Teamsters Union Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown, OH 44502

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

> You may designate a personal representative by completing a form that is available from the Fund Office.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by the plan. In addition, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent recognized as a personal representative may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Plan restrict information that goes to family members as described above at the beginning of Section 3 of this Notice.

Section 4: The Plan's Duties

Maintaining Your Privacy

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

> This notice is written to inform you of the Plan's obligation to maintain the privacy of your PHI.

This revised Notice is effective beginning on September 23, 2013 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

The Plan must limit its uses and disclosures of PHI or requests for PHI to the ***minimum necessary*** amount to accomplish its purposes.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your written authorization,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services, pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Final HIPAA Rule

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act generally referred to as the HIPAA Final Rule, are as follows:

- You have the right to be notified of a data breach relating to your unsecured health information.
- You have the right to ask for a copy of your electronic medical record in an electronic form provided the information already exists in that form.

- To the extent the Plan performs any underwriting the Plan cannot disclose or use any genetic information for such purposes.

- The Plan may not use your PHI for marketing purposes or sell such information without your written authorization.

Section 6: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the privacy officer:

> Teamsters Union Local No. 377 Health and Welfare Fund
> 1223 Teamsters Drive
> Youngstown, OH 44502

You have the right to file a complaint if you feel your privacy rights have been violated.

The Plan may not retaliate against you for filing a complaint.

You may also file a complaint with:

> Secretary of the U.S. Department of Health and Human Services
> Hubert H. Humphrey Building
> 200 Independence Avenue S.W.
> Washington, D.C. 20201

The Plan will not retaliate against you for filing a complaint.

Section 7: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the privacy officer at the Fund Office:

> Teamsters Union Local No. 377 Health and Welfare Fund
> 1223 Teamsters Drive
> Youngstown, OH 44502

Section 8: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

SECTION 25

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Fund shall not request or require an individual Participant or family member to undergo a genetic test provided, however this prohibition shall not limit the Plan from adjusting the employer's contributions based on the manifested disease of an individual covered under the policy. However, the Plan will not use the manifested disease to further increase the employer's contributions since, it also constitutes genetic information about family members covered under the Plan.

The Plan shall not request or require a Participant or family member to undergo a genetic test. Provided that such prohibition does not: (1) limit the authority of a health care professional to request an individual to undergo a genetic test; or (2) preclude the Plan from obtaining or using the results of a genetic test to make a determination regarding payment. The Plan shall request only the minimum amount of information necessary to accomplish the intended purpose.

The Plan is prohibited from requesting, requiring, or purchasing genetic information: (1) for underwriting purposes; or (2) with respect to any individual prior to such individual's enrollment or in connection with such enrollment.

SECTION 26
IMPORTANT INFORMATION ABOUT THE PLAN

Name of Plan – Teamsters Union Local No. 377 Health and Welfare Fund

Board of Trustees – The Board of Trustees, which consists of an equal number of employer and union representatives, is responsible for the operation of the Plan. If you wish to contact the Board of Trustees, you may use the address and phone number below.

Board of Trustees
Teamsters Local No. 377
Health and Welfare Fund
1223 Teamsters Drive
Youngstown, OH 44502

(330) 744-3148
(330) 744-4764 – FAX

Union Trustees:

Ralph (Sam) Cook
Teamsters Local Union No. 377
1223 Teamsters Drive
Youngstown, OH 44502-1348

Rich Sandberg
Teamsters Local Union No. 377
1223 Teamsters Drive
Youngstown, OH 44502-1348

Ken Sabo
Teamsters Local Union No. 377
1223 Teamsters Drive
Youngstown, OH 44502-1348

Employer Trustees:

Carmen Forde
Tamarkin Company
375 Victoria Rd.
Youngstown, OH 44515

Raymond A. Huber
Giant Eagle, Inc.
701 Alpha Dr., RIDC Park
Pittsburgh, PA 15238

Joseph Kerola
P I & I Trucking
P.O. Box 685
Sharon, PA 16146

Plan Sponsor and Administrator - The Board of Trustees is both the Plan Sponsor and Plan Administrator.

Identification Number – The Plan number assigned to this Trust by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The identification number assigned to the Board of Trustees by the Internal Revenue Service is 34-0755508.

Agent for Service of Legal Process – The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents may be served upon the Board of Trustees or any individual Trustee at the address of the Fund shown above, or upon any Trustee at his own address.

Collective Bargaining Agreements – This Plan is maintained pursuant to collective bargaining agreements. Plan Participants and beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed at the front of this booklet.

Source of Contribution – The Plan's benefit for eligible employees are provided through employer contributions. The amount of the employer contributions is determined by the provisions of collective bargaining agreements. Under certain circumstances, employee contributions are received by the Plan.

The Plan's benefits for eligible retirees are provided through retiree contributions. The required level of contributions is determined by the Trustees from time to time.

Insurance Companies – Self-funded medical benefit claims are administered pursuant to a group contract issued by Medical Mutual of Ohio. The Death Benefit, accidental death and dismemberment, weekly disability, dental and vision are self-insured by the Plan.

Trust Fund – All assets are held in trust by the Board of Trustees, and insurance premiums are paid from the Trust. The Plan Administrative Office pays all benefits which are self-insured by the Plan.

Fiscal Year – The Plan year for purposes of maintaining the Plan's Fiscal records is the twelve-month period beginning September 1st and ending August 31st.

SECTION 27
STATEMENT OF ERISA RIGHTS

As a participant (including retirees) in the Plan you are entitled to certain rights and protections under the ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examination, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5000 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5000 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relative to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child

support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.
ERISA requires that certain information be furnished to each participant in an Employee Benefit Plan. This booklet is the Summary Plan Description for purposes of ERISA.

SECTION 28
HIPAA SECURITY

The Plan and the Plan Sponsor agree to comply with the Security Regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160, 162, and 164 (the "Security Regulations"). The Security Regulations are incorporated herein by references, and, unless defined otherwise in the Plan in a way not inconsistent with the Security Regulations, all capitalized terms herein shall have the definition given to them by the Security Regulations.

These provisions shall apply to that Electronic Protected Health Information ("ePHI") created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan except, as provided in the Security Regulations, for ePHI (1) disclosed to the Plan Sponsor consistent with the provisions set forth in 45 CFR section 164.504(f)(1)(ii) or (iii), or (2) as authorized under the provisions set forth in 45 CFR section 164.508. To the extent any other terms of the Plan should conflict with the following provisions, the following provisions shall control.

The Plan Sponsor is required to and shall, in accordance with the Security Regulations:

(a) Implement Administrative, Physical, and Technical Safeguards (each as defined in 45 CFR § 164.304) that reasonably and appropriately protect the Confidentiality, Integrity, and Availability (each as defined in 45 CFR § 164.304) of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(b) Ensure that the adequate separation required 45 CFR section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures. In general, the required adequate separation means that the Plan Sponsor will use ePHI only for Plan administration functions it performs for the Plan.

(c) Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect information, including those security measures that are required pursuant to the HITECH Act.

(d) Obtain signed business associate agreements from the Plan's business associates that are updated to reflect the changes imposed by the HITECH Act.

(e) Report to the Plan any Security Incident of which it becomes aware, and to make such other reports, notices, and/or disclosures that are required pursuant to HITECH Act's Breach Notification Requirements.

SECTION 29
DEFINITIONS

Here are some definitions of terms used in this booklet, as they apply to your Plan.

Accidental Death – A death directly resulting from an accident, as defined, from an external cause, as opposed to death caused or contributed to by a disease or sickness.

Alcoholism – A condition classified as a mental disorder and described in the International Classification of diseases of the United States Department of Health and Human Services (ICD-9-CM), as alcohol dependence, abuse or alcoholic psychosis.

Allowed Amount - For PPO Network and Contracting Providers, the Allowed Amount is the lesser of the Negotiated Amount or Covered Charge. For Non-Contracting Providers, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Provider's Billed Charges.

Autotransfusion - withdrawal and reinjection/transfusion of the patient's own blood; only the patient's own blood is collected on several occasions over time to be reinfused during an operative procedure in which substantial blood loss is anticipated.

Appeal Process – If you are dissatisfied with the processing or decision regarding your claim, there is a claims appeal process which is outlined in this booklet. The appeal process allows you to have a separate review of your claim.

Application – All questionnaires and forms required by the Plan to determine your eligibility and insurability.

Authorization – Approval from Medical Mutual of Ohio (Medical Mutual) for non-contracting provider services, out-of-area services and elective hospital admissions and surgeries.

Benefit Period – The period of time during which you receive covered services as listed in the Schedule of Benefits.

Booklet or **Benefit Book** - means this document.

Charges – The provider's list of charges for services or supplies before any adjustments for discounts, allowances, incentives or settlements.

Child – Your natural child, adopted child, step-child or child for whom you are the legal guardian, or otherwise legally required to provide medical coverage.

Coinsurance – a percentage of either the Allowed Amount or Non-Contracting Amount for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

Coinsurance Limit – A specified dollar amount of coinsurance expense incurred in a benefit period.

Collective Bargaining Agreement – The agreement between your union and employer which governs the wages and conditions of your work.

Contracting/Participating Provider – The status of a hospital or other facility which has an agreement with Medical Mutual about payment for covered services.

Coordination of Benefits – This plan will coordinate its payment of benefits if a participant is covered by another group plan for health care. This will allow complete claim reimbursement, without providing duplicate payments.

Cosmetic Surgery – Reconstructive or plastic surgery done primarily to improve the physical appearance of a patient, but does not correct or improve a medical condition.

Covered Person – The participant, and if Family Coverage is in force, the eligible Dependents.

Covered Service – A provider's service or supply described in this booklet for which benefits will be paid as listed in the Schedule of Benefits.

Custodial Care – Care which does not require the constant supervision of skilled medical personnel to assist the patient in meeting his/her activities of daily living; such care can be taught to and administered by a lay person. Custodial care includes but is not limited to:

- administration of medication which can be self-administered or administered by a lay person with training; or
- help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of an injury, ailment, condition, disease, disorder or illness.

Deductible – The amount of covered expenses that a participant must satisfy before being eligible for Major Medical Expenses Benefit.

Dependent – For the purpose of the Plan, your legal spouse and your children to the age of 26 (See definition of Child). Permanently physically handicapped or mentally retarded children may have coverage after age 26.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a physician or other approved professional. These services are limited to the Diagnostic Services listed in the Schedule of Benefits.

Emergency Medical Condition - a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual

Employee – A person covered under a Collective Bargaining Agreement who is employed by an employer who must make contributions on their behalf to the Fund. Also, a person employed by a Local Union or a person employed by the Fund, who is otherwise covered under this Plan.

Employer – An employer who has a Collective Bargaining Agreement with the union and who meets the Trustees' requirements for participation in the Fund.

ERISA (Employee Retirement Income Security Act of 1974) – As a participant of the Plan, you have a number of rights under ERISA as outlined in this booklet.

Essential Health Benefits - benefits defined under federal law (PPACA) as including benefits in at least the following categories; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment;

prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care

Excess Charge – the difference between Billed Charges and the applicable Allowed Amount or Non-Contracting Amount. You may be responsible for Excess Charges when you receive services from a Non-Contracting Provider.

Experimental/Investigative – Any treatment, procedure, facility, equipment, drug, device or supply which we do not recognize as accepted medical practice or which did not have required governmental approval when you received it. Determination will be made by the Plan in its sole discretion and will be conclusive.

Fund – The Administrator of your Plan is Teamsters Local No. 377 Health and Welfare Fund.

Hospital – Any institution which is an approved and accredited hospital recognized as such by the American Hospital Association, which operates in caring and treating for sick and injured persons with surgical and diagnostic facilities and having 24-hour nursing service.

Identification Card – The health care card provided to you by the Plan. It shows your identification number.

Incurred – A charge will be considered incurred on the date a covered person receives the service or supply for which the charge is made.

Inhospital Benefit Period – A period of time beginning when you enter the hospital and ending when you have been out of the hospital for 90 consecutive days.

Inpatient – A covered person who receives care as a registered bed patient in a hospital or other facility for whom a room and board charge is made.

Major Medical Expense Benefit – After satisfaction of a deductible, a benefit which covers certain expenses for illness, injury or pregnancy in a calendar year.

Medically Necessary (or Medical Necessity) – A service or supply that is required to diagnose or treat an injury, ailment, condition, disease, disorder or illness and which the Plan determined is:

- Appropriate with regard to the standards of good medical practice
- Not primarily for the convenience of you or a provider
- The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an Outpatient

Medicare – The program of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Negotiated Amount - the amount the Provider has agreed with Medical Mutual to accept as payment in full for Covered Services, subject to the limitations set forth below.

The Negotiated Amount may include performance withholds and/or payments to Providers for quality or wellness incentives that may be earned and paid at a later date. Your Copayment, Deductible and/or Coinsurance amounts may include a portion that is attributable to a quality incentive payment or bonus and will not be adjusted or changed if such payments are not made. The Negotiated Amount for Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations, performance withhold adjustments or any settlement, incentive, allowance or adjustment that does not accrue to a specific

claim. In addition, the Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings (rebates), volume-based credits or refunds or discount guarantees. In certain circumstances, Medical Mutual may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Provider instead of Medical Mutual contracting directly with the Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement Medical Mutual has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

Network Provider – Any hospital, physician, specialist, laboratory or other health care provider who has been selected by Medical Mutual of Ohio to participate in the SuperMed Plus network.

Non-Participating/non-contracting Provider – the status of a Provider that does not have a contract with Medical Mutual or one of its networks.

Other Facility Provider – The following licensed facilities where covered services are provided: Alcoholism Treatment, Ambulatory Surgical, Day/Night Psychiatric, Dialysis, Drug abuse Treatment, Home Healthcare, Psychiatric and Skilled Nursing.

Outpatient – A covered person who receives services or supplies at a hospital, clinic, physician's office or treatment facility, but does not occupy a bed or stay overnight.

Participant – A person covered under a Collective Bargaining Agreement who is employed by an employer who must make contributions on their behalf to the Fund. Also, a person employed by a Local Union or a person employed by the Fund, who is otherwise covered under this Plan.

Physician – A doctor or surgeon licensed to practice medicine.

Plan – Your Health and Welfare Benefits. This booklet is your Plan Document and Summary Plan Description.

PPACA - Patient Protection and Affordable Care Act.

PReview Managed Care – The name for the utilization review and cost management programs available through Medical Mutual of Ohio.

Professional Providers – Only the following persons or entities which are licensed as required:

- Physical Therapists
- Podiatrist
- Psychologist
- Registered Nurse (R.N.)
- Certified Nurse Midwife (C.N.M.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)
- Laboratory (must be Medicare approved)
- Dentist
- Doctor of Chiropractic Medicine
- Mechanotherapist (licensed or certified prior to November 3, 1973)

Provider – A Hospital or Other Facility Provider.

Retiree – A former employee who satisfies the eligibility requirements set forth in this Plan for participation.

Skilled Care – Care which requires the skill, knowledge and training of a physician or a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a physician.

SuperMed Plus – The name of the health care coverage option offered by Medical Mutual of Ohio. This option consists of a network of hospitals, physicians and other providers. Maximum benefits are obtained by using SuperMed Plus network providers.
Allowed Amount
Union – Teamsters Local Union No. 377.

Utilization Review – The evaluation and promotion of efficient use of professional medical care services, procedures and facilities.

NOTE: Unwritten communications such as personal conversations with a Trustee, the Union, an Employer, or Plan employees should not be relied upon to change the terms of the written documents.

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